IS THIS ANY WAY TO TREAT OUR TROOPS? PART II: FOLLOW-UP ON CORRECTIVE MEASURES TAKEN AT WALTER REED AND OTHER MEDICAL FACILITIES CARING FOR WOUNDED SOLDIERS

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY
AND FOREIGN AFFAIRS

OF THE

COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

APRIL 17, 2007

Serial No. 110–16

Printed for the use of the Committee on Oversight and Government Reform

Available via the World Wide Web: http://www.gpoaccess.gov/congress/index.html
http://www.oversight.house.gov

U.S. GOVERNMENT PRINTING OFFICE

36–999 PDF WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
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CONTENTS

IS THIS ANY WAY TO TREAT OUR TROOPS? PART II: FOLLOW-UP ON CORRECTIVE MEASURES TAKEN AT WALTER REED AND OTHER MEDICAL FACILITIES CARING FOR WOUNDED SOLDIERS

TUESDAY, APRIL 17, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m. in room 2154, Rayburn House Office Building, Hon. John F. Tierney (chairman of the subcommittee) presiding.

Present: Representatives Tierney, Yarmuth, Braley, McCollum, Cooper, Van Hollen, Hodes, Welch, Shays, Burton, Turner, and Foxx.

Also present: Representative Cummings and Delegate Norton.

Staff present: Brian Cohen, senior investigator and policy advisor; Dave Turk, staff director; Andrew Su and Andy Wright, professional staff member; Davis Hake, clerk; David Marin, minority staff director; A. Brooke Bennett, minority counsel; Grace Washbourne, minority senior professional staff member; Nick Palarino, minority senior investigator and policy advisor; and Benjamin Chance, minority clerk.

Mr. TIERNEY. Good morning, everyone.

A quorum being present, the Subcommittee on National Security and Foreign Affairs' hearing entitled, "Is This Any Way to Treat Our Troops? Part II," will come to order.

I ask unanimous consent that only the chairman and ranking member of the subcommittee make opening statements. Without objection, so ordered.

I ask unanimous consent that the hearing record be kept open for 5 business days so that all members of the subcommittee will be allowed to submit a written statement for the record. Without objection, so ordered.

I ask unanimous consent that the following written statements be placed on the hearing record: Dr. Allen Glass, a military physician who has worked at Walter Reed for 20 years; Gary Knight, a former patient at Walter Reed; Patrick Hayes, a police officer who has worked at Walter Reed for almost 20 years; Dr. Richard Gardner, who worked at Winn Army Community Hospital at Fort Stewart in Georgia; Specialist Stephen Jones, an Iraqi veteran; and Cor-

poral Steve Schultz and his wife, Debbie. Without objection, so ordered.

I ask unanimous consent that the gentleman from Maryland, Representative Cummings, and the Delegate from the District of Columbia, Representative Eleanor Holmes Norton, members of the full Oversight and Government Reform Committee, be permitted to participate in the hearing. In accordance with our committee practices, they will be recognized after members of the subcommittee. Without objection, so ordered.

We will proceed to opening statements.

I want to just say good morning to everybody here on the panel and all of our witnesses on both panels here today. On March 5th, you will recall that this subcommittee convened our first ever hearing on the care of wounded soldiers at Walter Reed Army Medical Center. I think it is fair to say that all of us were appalled by the heart-wrenching stories from Staff Sergeant Dan Shannon, Annette McCleod, and Specialist Jeremy Duncan. They spoke of living with mold, being lost in the bureaucratic abyss, and being treated with a shameful lack of respect.

But their stories are not, unfortunately, isolated incidents. After our first hearing, we created a special hotline, an e-hotline. We heard from hundreds of people, and the problems went well beyond Walter Reed.

A doctor who had come out of retirement to help out at Winn Army Community Hospital at Fort Stewart, GA, said that there they were understaffed, overextended, and "much worse than at Walter Reed."

A soldier who fought in both Gulf wars spoke of cuts in the soldier advocate program at Darnall Army Medical Center in Fort Hood, Texas, and that traumatic brain injury patients were being un- or under-diagnosed.

Someone at 29 Palms Marine Base witnessed examples of post traumatic stress disorder going undiagnosed, untreated, and purposefully ignored to return soldiers to active duty. She told us about one navy psychiatrist who said "clearly he did not believe in PTSD."

We also, unfortunately, heard additional troubling stories about Walter Reed.

A 20-year police veteran there wrote of cockroaches and mice at their police station. He also wrote, "The [police] station is not handicapped accessible, which is ironic considering we have a large number of handicapped veterans here that may need to come to our station for police services."

A Walter Reed JAG lawyer spoke of a broken disability review process that under-rates wounded soldiers, a system in which there were only three JAG officers and one civilian counselor available to represent all wounded soldiers at Walter Reed; a system so overburdened there was no time to get an outside medical opinion or to adequately prepare for these absolutely vital hearings.

We also heard in the media about computer programs that can't talk to each other, a growing backlog of VA disability claims, and egregious allegations of still-injured soldiers being returned into battle.

At our March hearing, with the committee's support, I made the commitment that this subcommittee would perform sustained and aggressive oversight, and as a first step we would followup with a hearing in 45 days.

Today marks the 43rd day, and I hope we will hear across the board from our witnesses that the Department of Defense acknowledges the seriousness and pervasiveness of these problems; that we are rapidly fixing the broken bureaucracy, knocking down the institutional walls across the services and with the VA Administration, and ensuring that each soldier and his or her family is treated with the utmost respect. That is what we hope we can hear.

We will hear today from the Independent Review Group, led by distinguished former Army Secretaries Togo West and Jack Marsh. Their report, released yesterday, examines the problems at Walter Reed and elsewhere and offers a series of recommendations.

I want to thank all of the IRG members and your staff for your work, and welcome those members here with us today. I don't know if staff is here or not. At some point you may want to acknowledge them. They certainly did a great job, as did you, and we are really indebted to them and you for your service.

As I suspect all these members will likely agree, we have heard many, if not the vast majority, of these findings and recommendations from testimony before Congress, from the Government Accountability Office auditors, even from the President's own 2003 Task Force to Improve Health Care Delivery for Our Nation's Veterans. But the problems have not yet been fixed.

In February, this subcommittee asked the Defense Department for documents on the problems at Walter Reed. These documents show a rash of complaints about the now-infamous Building 18, including mold, mouse droppings, roaches, and flea bites so severe they required medical attention.

There is a slide over there that indicates one of the complaint forms that we received.

What is shocking is that these documents don't recount the recent problems that were exposed by the Washington Post in February. What is remarkable is that these complaints happened in the summer of 2005, well before the Post investigation. The documents show that, as a result, Building 18 was shut down. In the words of the Walter Reed Inspector General at that time, "Building 18 was not up to standards for occupancy, and it has been temporarily evacuated of all personnel."

But then Building 18 was reopened. Specialist Jeremy Duncan and others moved in; and inexplicably the same exact thing happened again.

I hope that we don't do here with respect to the broader problems identified by the IRG Group and others is to "Building 18" them; that is, to simply paint over the problems. We literally and figuratively need to knock down some walls, to roll up our sleeves, and to work together to completely overhaul the disability ratings process and to figure out how best to deal with traumatic brain injuries. Put simply, we need to tackle head-on the most difficult problems instead of once again simply covering them over with half-measures.

The fundamental question we all have to ask ourselves now is: what is going to be different this time around in order to actually solve these problems?

I am encouraged that the Independent Review Group has assigned specific responsibility to specific officials for specific recommendations, so that 2 years down the road officials can't just claim that solving a certain problem was somebody else's responsibility.

Many of those who will be responsible and accountable going forward will testify on our second panel today. What I want to know is very simple: what is going to be different this time around under your watch to solve these problems once and for all?

Be assured that as you continue your work, this committee will be right there with you—offering constructive advice and support where helpful, but also ready to hold people accountable where necessary.

Our mutual goal of ensuring the proper care and respect for each patient at each step of the recovery process demands nothing less. The American people don't want to hear any excuses or empty promises. Our Nation's soldiers and their families deserve better.

These are difficult challenges and it will take our cooperative efforts, all of us working together, to make sure that this broken system is fixed, fixed quickly, and fixed permanently.

I recently led a bipartisan congressional delegation to Afghanistan and met with our soldiers there, including some from our Commonwealth of Massachusetts, a young man from Waltham, MA, there on the monitors. If, God forbid, any one of them gets injured, they deserve to come home to a hero's welcome and to the best care and utmost respect we can give them, not to a building with mold and mouse droppings, not to a maze of impenetrable bureaucracy, and not to a system that works against the very soldiers it should be supporting. That, to me, and I think to members of this panel, is the job that faces us today.

[The prepared statement of Hon. John F. Tierney follows:]

FROM THE OFFICE OF JOHN F. TIERNEY
Representing Massachusetts's 6th District

For Immediate Release
April 17, 2007

Contact: Catherine Ribeiro
(202) 225-8020

NATIONAL SECURITY SUBCOMMITTEE HOLDS FOLLOW-UP WALTER REED HEARING

"Is This Any Way To Treat Our Troops? – Part II: Follow-Up on Corrective Measures Taken At Walter Reed and Other Medical Facilities CaringFor Wounded Soldiers"

WASHINGTON, DC —Today, the Subcommittee on National Security and Foreign Affairs held an oversight hearing to examine the actions taken by the Pentagon in response to the Subcommittee's March 5, 2007 field hearing on allegations of unacceptable care and living conditions of wounded soldiers housed at the Walter Reed Army Medical Center in Washington, DC and other similar military facilities across the country. This hearing was in keeping with Chairman Tierney's promise to continue oversight on this issue and hold an additional hearing within 45 days to assess progress made to fix these problems.

A copy of Chairman Tierney's opening statement as prepared for delivery is below:

Good morning. On March 5th, this new Subcommittee convened our first ever hearing on the care of wounded soldiers at Walter Reed Army Medical Center. I think it's fair to say that all of us were appalled by the heart-wrenching stories from Staff Sergeant Dan Shannon, Annette McLeod, and Specialist Jeremy Duncan. They spoke of living with mold, being lost in a bureaucratic abyss, and being treated with a shameful lack of respect.

But their stories are not, unfortunately, isolated incidents. After our first hearing, I created a special e-hotline. We heard from hundreds of people, and the problems went well beyond Walter Reed:

- A doctor who had come out of retirement to help out at Winn Army Community Hospital at Fort Stewart, Georgia, said they were understaffed, over-extended, and I quote, "much worse than at Walter Reed."

- A soldier who fought in both Gulf wars spoke of cuts in the soldier advocate program at Darnall Army Medical Center at Fort Hood, Texas, and that traumatic brain injury patients were being un- or under-diagnosed.

- Someone at 29 Palms Marine base witnessed examples of post-traumatic stress disorder going undiagnosed, untreated, and purposefully ignored to return soldiers to

active duty. She told us about one navy psychiatrist who, and I quote, "said clearly he did not believe in PTSD."

We also, unfortunately, heard additional troubling stories about Walter Reed:

- A 20-year police veteran there wrote of cockroaches and mice in their station. He also wrote, and I quote: "The [police] station is not handicapped accessible, which is ironic considering we have a large number of handicapped veterans here that may need to come to our station for police services."

- A Walter Reed JAG lawyer spoke of a broken disability review process that under-rates wounded soldiers; a system in which there were only three JAG officers and one civilian counselor available to represent all wounded soldiers at Walter Reed; a system so overburdened there was no time to get an outside medical opinion or to adequately prepare for these absolutely vital hearings.

We've also heard in the media about computer systems that can't talk to each; a growing backlog of VA disability claims; and egregious allegations of still-injured soldiers being returned into battle.

At our March hearing, I made the commitment that this Subcommittee will perform sustained and aggressive oversight, and as a first step we would hold a follow-up hearing within 45 days.

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We will hear today from the Independent Review Group (IRG), led by distinguished former Army Secretaries Togo West and Jack Marsh. Their report, released yesterday, examines the problems at Walter Reed and elsewhere, and offers a series of recommendations. I want to thank all of the IRG members and staff for your work, and welcome those members here with us today.

As I suspect all these members will likely agree, we've heard many, if not the vast majority, of these findings and recommendations before – from testimony before Congress, from the Government Accountability Office auditors, even from the President's own "2003 Task Force to Improve Health Care Delivery for Our Nations Veterans."

But the problems have not yet been fixed.

In February, this Subcommittee asked the Defense Department for documents on the problems at Walter Reed. These documents show a rash of complaints about the now-

infamous Building 18, including mold, mouse droppings, roaches, and flea bites so severe they required medical attention.

What's shocking is that these documents don't recount the recent problems exposed earlier this year by the Washington Post.

What's remarkable is that these complaints happened in the summer of 2005 – well before the Post investigation. The documents show that, as a result, Building 18 was shut down. In the words of the Walter Reed Inspector General: "Building 18 was not up to standards for occupancy, and it has been temporarily evacuated of all personnel."

But then Building 18 was reopened; Specialist Jeremy Duncan and others moved in; and inexplicably the exact same thing happened again.

I hope that what we don't do here with respect to the broader problems identified by the Independent Review Group and others is to "Building 18" them; that is, to just paint over the problems.

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Be assured that as you continue your work, this committee will be right there with you – offering constructive advice and support where helpful, but also ready to hold people accountable where necessary. Our mutual goal of ensuring the proper care and respect for each patient at each step of the recovery process demands nothing less.

The American people don't want to hear any excuses or empty promises. Our nation's soldiers and their families deserve better. These are difficult challenges, and it will take our cooperative efforts – all of us working together – to make sure this broken system is fixed, fixed quickly, and fixed permanently.

I recently led a bipartisan Congressional delegation to Afghanistan and met with our soldiers there, including some from my home commonwealth of Massachusetts.

If, God forbid, any one of them gets injured, they deserve to come home to a hero's welcome and to the best care and utmost respect we can give them, not to a building with mold and mouse-droppings, not to a maze of impenetrable bureaucracy, and not to a system that works against the very soldiers it should be supporting.

That, to me, is the job facing all of us today.

-30-

The Complainant stated that when he arrived at … building 18 on June 27, 2005, his room was dirty, with mildew/mold and no A/C … He received fleabites on his ankles… He found mouse droppings in his wall locker and around the toilet*

*ARMY Inspector General Action Request System Report Case # HW050312

SAIG

Department of the Army
Inspector General Action Request System

Thursday, August 18, 2005 — Electronic 1559 — Page 1 — HW050312

Case Number: HW050312 Close Date: 18-August-2005 Open Date: 02-August-2005
Suspense Date: External Suspense Date:
Complaint Made To: Army IG Receipt Mode: Walk-In
Case Status: Closed Non-IG Referral:

Initiator Information: Name Last: [redacted] First: [redacted] M.I.: [redacted] SSN: [redacted]
Component: Active Army Grade: E4 Gender: Male
Acknowledge Date: 10-August-2005 Home UIC: Race: Unknown

Complainant Information: Name Last: [redacted] First: [redacted] M.I.: [redacted] SSN: [redacted]
Component: Active Army Grade: E4 Gender: Male
Home UIC: Race: Unknown

Case Label: [redacted] Home IG:
Problem Area: Troop housing/barracks

Notification Date: Inspector General: MSG [redacted]
Location: Walter Reed Army Medical Center, Washington, District of Columbia

Subject Information: Last Name: First: M.I.: SSN:
Component: Grade: Gender:
Race: Organization ID:

Other Issues or Allegations: Function: EJ VOQ/BOQ/BEQ/Troop Housing
Determination: Assistance
User Data: TIM Category: C Operation:
Organization ID: Walter Reed Army Medical Center

On August 1, 2005, the WARMC Inspector General Office received an IGAR from SPC [redacted]. The complainant requests assistance in improving the living conditions at the Old student Company and at the New Student Company. The complainant stated that when he arrived at the Student Company building 18 on June 27, 2005, his room was dirty, with mildew/mold and no A/C. The complainant stated that he received fleabites on his ankles. The complainant stated that he found mouse droppings in his wall locker, and around

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Mr. TIERNEY. Mr. Shays.

Mr. SHAYS. Thank you very much, Mr. Chairman and my colleagues. Mr. Chairman, I thank you for your commitment to this subcommittee's bipartisan inquiry of medical care for our men and women returning from war. If an American injured on the battle field in Afghanistan or Iraq arrives quickly to a major surgical facility, the chances are he or she will be kept alive. If the wounded are transferred to Walter Reed Hospital, the medical care they receive is unparalleled.

But it is after the soldier is treated and then transferred into outpatient care that breakdowns occur, both in the delivery of outpatient services and with the outpatient facilities, themselves. We have seen the deplorable conditions of Building 18 and the Byzantine bureaucracy through which wounded warriors and their families are subjected.

These breakdowns, in and of themselves, do not define the medical care offered at Walter Reed; however, they are clear indications of systemic failings in the outpatient program. No one should have to live in conditions like those reported in Building 18, and it goes without saying that an outpatient should be treated with the same care and focus as an in patient. The medical treatment of our wounded warriors is non-negotiable, and our servicemen and women have earned the right to a continuum of care that sets standards.

Central to the military creed is the promise to leave no soldier or Marine on the battlefield, but by subjecting our recovering soldiers and their families to appalling outpatient conditions we have done just that. We have failed in our responsibility to ensure the care of our brave men and women, and our task today and into the future is to ensure our war wounded are being cared for completely and for as long as they need care.

This committee's oversight into these matters, which started under Chairman Tom Davis, has been long and protracted. We have heard excuses and promises of improvements, promises of changes, and promises that this time things are really going to get better. What is different is the imprint of the graphic representations of Building 18 and the accompanying calls for action have forced action.

We want to hear what actions to correct these failings have been taken and what actions are planned. We also want to hear what we collectively need to do to ensure this does not happen in the future.

The Wounded Warrior Assistance Act of 2007, which was passed unanimously out of the House, provides a good start toward the comprehensive reform of military medical programs, but it does not go far enough. Toward that end, a number of us advocated for comprehensive legislative proposals designed to streamline processes for our war wounded and their families caught in the Department of Defense's never-ending bureaucratic maze. These proposals were based on the work of this committee and subcommittee and were vetted through patients we have helped in the past. These proposals included establishing medical holdover, MHO, process reform standards to create comprehensive oversight of all military medical facilities, patients, and hospital staff, and a patient navigator's pro-

gram where independent navigators serve as representatives for patients and families.

Our committee should support legislation supporting a DOD-wide ombudsman to assist wounded military and their families 24/7 and establish the standard soldier patient tracking system to help family members, installation commanders, patient advocates, or ombudsmen office representatives locate any patient in the medical holdover process.

We look forward to hearing other solutions today. We view this hearing as an opportunity to identify the best possible policies and legislation as required to rehabilitate Walter Reed. Goodwill and faith in our military medical system will be replenished not by excuses and promises but by solutions and actions. We support you, General Schoomaker, and each of our witnesses in this process.

Nearly 150 years ago Abraham Lincoln closed his second inaugural address with the following words: "Let us strive on to finish the work we are in, to bind up the Nation's wounds, to care for him who shall have born the battle, and for his widow and his orphan." To care for him who shall have born the battle, such was our duty 150 years ago and remains our duty today.

I look forward to our witnesses' testimony today and thank each of them for their hard work over the past few months.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Christopher Shays follows:]

OPENING STATEMENT OF
RANKING MEMBER CHRISTOPHER SHAYS

"IS THIS ANY WAY TO TREAT OUR TROOPS - PART II:
FOLLOW UP ON CORRECTIVE MEASURES AT WALTER REED"
TUESDAY, APRIL 17, 2007

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"To care for him who shall have borne the battle." Such was our duty 150 years ago and remains our duty today.

I look forward to our witnesses' testimony today and thank each of them for their hard work over the past months.

Mr. TIERNEY. Thank you, Mr. Shays.

We are going to hear testimony from our panel at this point in time, but I want to begin by introducing the witnesses on our first panel who look to be almost all of the entire Independent Review Group. A few are missing. Two are missing, Mr. Schwartz and one other.

I am going to introduce them in the order in which they are sitting to help people.

To my far left is Mr. Lawrence Holland, senior enlisted advisor to the Secretary of Defense for Reserve Affairs. Next is the Honorable Jack Marsh, the former Secretary of the Army, who is the co-chair of the IRG; Togo West, former Secretary of the Army and former Secretary of Veterans Affairs, the other co-chair of the IRG; Mr. Charles Chip Roadman, formerly an Air Force Surgeon General. We have Arnold Fisher, the senior partner of Fisher Brothers New York and chairman of the Board for the Intrepid Museum Foundation, amongst other responsibilities; and last General John Jumper, General, the U.S. Air Force, retired, who was the Chief of Staff of the Air Force from 2001 to 2005.

I want to welcome all of you and thank you again for the work that you have done and the report entitled, Rebuilding our Trust, which is a significant piece of work, considering we only had about 43 or 45 days to do it.

It is the policy of the subcommittee to swear you in before you testify, so I ask you to please stand and raise your right hands. If there is anybody else who is going to be asserting answers to any of your responses, I ask that they also stand and be sworn in.

[Witnesses sworn.]

Mr. TIERNEY. Note that the witnesses answered in the affirmative.

I understand that one of two of you will be giving a single opening statement. I remind you that our opening statements are generally about 5 minutes. We won't hold you exactly to that line, but if you would summarize it to 5 minutes then we will have more time to ask questions and elicit as many responses as we can.

Mr. SHAYS. Mr. Chairman, before we begin could I just insert in the record the statement of Tom Davis, who is visiting with family because of the horrific tragedy yesterday at the campus in Virginia. So he has a statement, and I would like to submit that for the record.

Mr. TIERNEY. Without objection. Thank you.

[The prepared statement of Hon. Tom Davis follows:]

Statement of Rep. Tom Davis
Subcommittee on National Security and Foreign Affairs
Committee on Oversight and Government Reform
[
"Is This Any Way to Treat Our Troops: The Care and Condition of Wounded Soldiers at Walter Reed – Part II

April 17, 2007

Chairman Tierney, today this Subcommittee is doing something that just didn't happen often enough at Walter Reed: follow-up. At this Subcommittee's hearing in March, we heard plans for improvement in outpatient care and we heard promises to pursue those plans with urgency. The Government Reform Committee had heard many of those plans and promises before, starting as far back as 2004 when we exposed rampant pay errors that were financially crippling already wounded soldiers. After so many promises, but so little progress, we need to start seeing concrete results, and I applaud your persistence in pursuing these issues.

We need to hear about actions being taken now to fix a military medical system that's too old, too small and too slow to give war veterans the care they've earned. Those heroes need actions, not words. Studies, tiger team reports and task force recommendations might be useful to chart a long term course. But there are steps that can and should be undertaken right now to improve the efficiency and medical effectiveness of post-combat care.

Actions taken since the February disclosure of deplorable living conditions at Walter Reed have begun to improve the standard of care for outpatients there and at other Department of Defense treatment facilities. But the system still lacks consistent clinical standards and clear administrative procedures to move patients seamlessly through the healing and disability review process.

Recommendations by the DOD Independent Review Group reflect an understanding of the qualitative and quantitative challenges confronting a system built for

the last war, not the long war we are fighting today. The IRG findings acknowledge that care for the wounded still lacks adequate capacity, continuity and compassion.

But the IRG report does not always squarely face the hard realities blocking real and immediate progress. The current cumbersome, fragmented system of care reflects more than a clash of military service "cultures." Resistance to a truly joint solution seems deeply encoded in the Pentagon's institutional genetics and will not easily give way to unified civilian controls and oversight.

And the problems faced by National Guard and Reserve members are – based on the calls my office is still receiving – very real, not just a question of "perception." The unique problems encountered in moving from reserve component status to active duty, and back, demand fully integrated data systems and administrative procedures. All those who fight as part of the "total force" should receive the same high-quality care and service.

In terms of capacity, the decision to close Walter Reed may need to be revisited, not accelerated. Even after new facilities are built, we may not have the option to take inpatient beds or outpatient facilities off-line while sustaining the highest standard of care, appropriate patient-to-staff ratios and process timeliness.

A last century medical system also lacks the vision to see and treat the invisible wounds of modern war – traumatic brain injuries and Post Traumatic Stress Disorder. Clinical standards for early diagnosis and treatment of these casualties are needed, as is training for medical and administrative staff charged to heal body and mind. Provisions recently passed by the House address some of these shortfalls, but much more remains to be done. I and others have proposed establishing clear quality standards and performance metrics for the entire outpatient system to constantly monitor the pulse of this vital process. We shouldn't have to wait for media exposes to know patients are getting substandard treatment or enduring months of delay to get implausibly low disability ratings.

The problems hobbling military medical care are deeply rooted. A calcified *status quo* will not reform itself, and timid, marginal fixes will not do the job. Without sustained leadership, adequate resources and close oversight, the plans and promises for improvements we've heard about will remain just that: plans and promises. Only concerted action can ensure we leave no more wounded Americans behind on the bureaucratic battlefield.

Hearings like this are an essential ingredient of the cure for what ails Walter Reed specifically, and military outpatient services generally. I look forward to our witnesses' testimony and a frank, constructive discussion of the tangible reforms being pursued to make sure our wounded warriors receive the care they deserve.

Mr. TIERNEY. Secretary Marsh will start.

STATEMENTS OF THE INDEPENDENT REVIEW GROUP CHAIRMEN AND MEMBERS: TOGO D. WEST, JR., FORMER SECRETARY OF VETERANS AFFAIRS AND FORMER SECRETARY OF THE ARMY; JACK MARSH, FORMER SECRETARY OF THE ARMY; ARNOLD FISHER, SENIOR PARTNER FISHER BROTHERS NEW YORK AND CHAIRMAN OF THE BOARD FOR THE INTREPID MUSEUM FOUNDATION; LAWRENCE HOLLAND, SENIOR ENLISTED ADVISOR TO THE SECRETARY OF DEFENSE FOR RESERVE AFFAIRS; CHARLES "CHIP" ROADMAN, FORMER AIR FORCE SURGEON GENERAL; AND GENERAL JOHN JUMPER

STATEMENT OF TOGO G. WEST, JR.

Mr. WEST. There are two of us that will give statements, but we will meet your 5 minute requirements.

Mr. TIERNEY. I have read your statements. I think you can do it. If you have to go over, go right ahead.

Mr. WEST. Thank you.

I would like to add that seated immediately behind us in the first row is Rear Admiral retired Kathy Martin, former Deputy Surgeon General of the U.S. Navy and a member of our panel. She stood for the swearing in.

Mr. Chairman, members of the committee, let me offer just a few comments with respect to our report and to what we at the IRG did.

Walter Reed Army Medical Center bears the most distinguished name in American military medicine. It and its colleague to the north, the National Medical Center at Bethesda, set the standard for DOD medicine. Our review suggests, however, that, although Walter Reed's rich tradition of flawlessly rendered medical care of the highest quality, as you have pointed out, remains unchallenged, its highly prized reputation has, nonetheless, been justifiably but not irretrievably called into question in other respects. Fractures in its continuum of care and support for its outpatient service members have been reported and are being reviewed. We have reviewed them.

Failures of leadership virtually incomprehensible, in attention to maintenance of non-medical facilities, and a reportedly almost palpable disdain for the necessity of continuing support for patients and their families have led the growing list of indictments against this once and still proud medical facility.

Our recommendations cover a wide range. I have tried to lump them into four quick questions. Firstly, who are we as a country, as a military, as health care centers here in the Nation's Capital? Unfortunately, if one considers the reports you and we have received from service members and their families, we would conclude that we may be answering that question in ways that are not attractive to us as military services or as a Nation. We say much about ourselves by the attitudes we display toward those who look to this Nation for support at their most vulnerable time.

A number of findings and recommendations involving the assigning and training of case workers, increases in the numbers of case

workers, adjustment of the case-worker-to-patient ratio, assignments of primary care physicians, and attention to the nursing shortages consequently have been included in our report.

Second, who are we and what are we to become? The base realignment and closure process and the A–76 process have caused incalculable dislocations in Walter Reed operations, and they threaten the future of both installations.

We concluded that BRAC should proceed for a host of reasons, but we also concluded that the transition process is lacking, important coordinating efforts between the two installations need to be improved, and increased pace for the transition is urgently needed.

Third, how are our service members doing? At every turn we encountered service members, families, professionals, thoughtful observers who pointed out the impact of TBI, traumatic brain injury, and PTSD, post traumatic stress disorder, and how challenging they have become, challenging in terms of DOD and Department of Veterans Affairs diagnosis, evaluation, and treatment, challenging in terms of the ability of our system to respond to them.

We offer detailed recommendations with respect to both a center of excellence for the treatment, research, and education with respect to these challenges, and increased attention to cooperative efforts by both Cabinet departments.

And finally, fourth, how long? The IRG has operated with what is, for me, a rare sense of unity and cooperation for organizations of this sort. But if there is one thing that we are most unified on, it is the need to put the horrors that are inflicted upon our service members and their families in the name of disability review and determinations, bring those horrors to an end.

So our recommendations are several, but our thrust is one, and that is that the process needs to become one single process.

It is no surprise to you nor to us that Government and its various parts can offer rationalizations, good ones, in fact let me say reasonable arguments as to why each part of that process needs to be reserved for a specific purpose, but we are a Nation that values the sense of common Americans. We call it common sense, and common sense tells us that, from the patients and the service member and the families' point of view, it is an incredible maze.

Thus, virtually every finding leads back to those four things: leadership and attitude; the transition from Walter Reed Army Medical Center to Walter Reed National Military Medication Center; the extraordinary use of IEDs—improvised explosive devices—and the current wars in the current two areas of conflict, and their impacts on the brains and psyches of our service members; and the longstanding and seemingly in tractable problem of reforming the disability review process.

To be sure, it was the degradation of facilities that first caught the eye of media reporters, but that is not our bottom line at the Independent Review Group. That bottom line is this: we are the United States of America. These are our sons and daughters, our brothers and sisters, uncles, and an occasional grandparent or two. We can and must do better.

Thank you.

STATEMENT OF JACK MARSH

Mr. MARSH. Mr. Chairman, thank you for conducting this hearing. It is very, very important. All of the departments, all of the services have been extremely cooperative in assisting us in this review, and members of our panel are very outstanding resource people, and some of your questions really should go to them, because they have backgrounds in medicine and hospital management and areas that we do not have.

So we have had great experience and help from the Department, and I would tell you that under the leadership of the new commander at Walter Reed, General Schoomaker, who is here, and the new Acting Surgeon General, Gale Pollack, I think you are going to see some real progress.

But, by way of background, I am a veteran of World War II, served and retired as a National Guard officer in the Virginia Guard, former Member of the U.S. Congress from Virginia. Both of our sons were called to active duty and took part in combat operation in the Persian Gulf. Our oldest son, a doctor, was a surgeon for the Delta Force, and was severely wounded in Mogadishu, but it gave us an insight to what families must go through in these circumstances and how important it is.

We also saw the magnificent medical care that our son received, and also I am eternally grateful to the U.S. Air Force for the airlift capabilities that they have. Go down to Andrews some evening when one of the cargo flights carrying people come in these litters and you will come away with an enormous admiration and respect for our medical community and the Air Force.

I make a point of that because I believe there is a part of the American ethic, and that American ethic is that America takes care of its wounded. I knew that when I was in the service, myself, I have seen it since, and I observed it, as did Togo when he was Secretary of the Army. Incidentally, he brought to our panel an enormous capability in his background with the Veterans Administration. Veterans Affairs has been exemplary and very, very helpful.

You are focusing on families, and I encourage you to do that, not just to the active, but focus on the Guard and Reserve. Their family support systems are different, and it also imposes different requirements.

It has been said that at Walter Reed it was a confluence of circumstances that became the Perfect Storm. The combination of A–76, the requirement to contract out some 300 plus jobs, it took over 5 years to address. So we had not only A–76, you had the BRAC. Then you had enormous increase of the number of casualties. So it came into a confluence in a way that was very difficult to deal with.

There are problems that you have identified and which you hear on the disability evaluation system. The standards are not clear inside the Army, and they are not clear between the Army and the Air Force or with the Navy or with the Department of Defense. The medical community in many areas is in a sea of bureaucracy and red tape that is creating enormous problems for these service people. If you want to move quickly, move there. Look at that red tape, the bureaucracy.

There is beginning to develop problems in recruiting for the medical community. I would suggest you also look at amending the statute that permits the recruitment of doctors who are over 50 but do not impose on them the 8 year obligation rule. It is a rare opportunity to avail yourselves and the armed services of the kind of medical attention they need and deserve.

Now, finally, as a Member of the Congress at one time I am aware that only the Congress of the United States can fix and address the real systemic problems that we are looking at here. I suspect that the systemic problems that have been evidenced at Walter Reed you are going to find evidenced in other places. It was not our task to look at those, but I think they were there.

But the Congress has the constitutional authorities, article 1, section 8, to raise the Army's and Navy's and to provide and maintain their support. Please, I beg of you, have the commitment and the perseverance to see through that legislative challenge. It will not be easy, but it is vital to our country and it is vital to those who bear the brunt of war and who are wounded in doing that.

Thank you for addressing this issue.

[The prepared statement of Messrs. West and Marsh follows:]

Joint Opening Statement

By

The Honorable Togo D. West, Jr.

And

The Honorable John O. "Jack" Marsh, Jr.

Co-Chairmen
Independent Review Group on
Rehabilitative Care and Administrative Processes at
Walter Reed Army Medical Center and
National Naval Medical Center

Before the

United States House of Representatives
Committee on Oversight and Government Reform
Subcommittee on National Security and Foreign Affairs

April 17, 2007

Chairman Tierney, Mr. Shays, distinguished members of the Committee, thank you for this opportunity to discuss the findings of our Independent Review Group.

Before we begin our remarks, I would like to introduce the members of the Group who have joined us today.

The Honorable John O. "Jack" Marsh, Jr., my Co-Chair and a World War II veteran, who has served the Commonwealth of Virginia and the nation, right here in these hallowed halls of the United States Congress, also served as Secretary of the Army.

Mr. Arnold Fisher, a senior partner at Fisher Brothers in New York City, an Honorary Knight of the British Empire, and former Chairman and CEO of the Zachary and Elizabeth Fisher House Foundation; a man whose name is well-known to our injured and ill service members and their families.

Lieutenant General Charles "Chip" Roadman, US Air Force Retired, Chairman of the Board of Trustees of Altarum, retired as the Surgeon General of the Air Force in 1999.

Command Sergeant Major Lawrence "Larry" Holland, a consultant with Strategic Solutions Incorporated retired as the Senior Enlisted Advisor to the Assistant Secretary of Defense for Reserve Affairs with 37 years of military service.

The other members of the Group could not be present today; they include The Honorable Joe Schwarz, former congressman from Michigan; The Honorable Jim Bacchus, former congressman from Florida; General John Jumper, US Air Force Retired, former Chief of Staff of the US Air Force; Rear Admiral Kathy Martin, US Navy Retired, former Deputy Surgeon General of the US Navy.

Members of the Committee, if we may, we would like to offer a few words summarizing what the Independent Review Group found.

Walter Reed Army Medical Center bears the most distinguished name in American military medicine. It, along with its equally well-known colleague to the North – the National Naval Medical Center in Bethesda, Maryland – is the acknowledged flagship installation of DoD medicine.

Our review – by the Independent Review Group – suggests, however, that although Walter Reed's rich tradition of flawlessly rendered medical care of the highest quality remains unchallenged, its highly prized reputation has nonetheless been justifiably, but not irretrievably, called into question in

other respects. Fractures in its continuum of care, especially as it pertains to care and support for its out-patient service members have been reported and are being reviewed not only by us but by a veritable cavalcade of panels, organizations, officials and, those who report upon our daily national life electronically and in daily or periodic publications – and justly so. Failures of leadership, virtually incomprehensible inattention to maintenance of non-medical facilities; and a reportedly almost palpable disdain for the necessity of continuing support for recovering patients and their families have led the growing list of indictments of this once and still proud medical facility.

Our report's findings and recommendations cover a wide range of issues and circumstances which have come to our attention. They appear to converge, however, around four core concerns. Let me pose them as questions.

Firstly, who are we – as a country, as a military, as health care centers here in the nation's capital? Unfortunately, if one considers reports we have heard from service members and their families about the lapses in support to them during their rehabilitation phase of care, we would conclude that we may be answering that question in ways that are not attractive to us as an Army, a military, or as a nation. We say so much about ourselves by the attitudes we display towards those who look to the Nation for supports

during the most vulnerable times of their lives. We considered a number of findings and recommendations involving the assignment and training of caseworkers, increases in the numbers of caseworkers and adjustment of the caseworker to patient ratio, assignments of primary care physicians, and attention to the nursing shortages.

Secondly, who and what are we to become? The Base Realignment and Closure (BRAC) process and the A-76 process have caused incalculable dislocation in Walter Reed operations and threaten the future of both installations. BRAC should proceed for a host of reasons; but the transition process is lagging, important coordinative efforts between the two installations do not appear promising, and an increased pace for the transition is urgently needed.

Thirdly, how are our service members doing? At every turn, the IRG has encountered service members, their families, health care professionals, and thoughtful observers who point out how challenging the traumas associated with TBI (traumatic brain injury), and PTSD (pot traumatic stress disorder) have become; and how challenging they have been in terms of both DoD and Department of Veterans Affairs diagnosis, evaluation, and treatment. We believe there is a need for greater and better coordinated research in this area. We offer a somewhat detailed recommendation with

respect to a center of excellence and increased attention to cooperative efforts by both Cabinet departments.

Fourth, how long? The IRG has operated with what is, for me, a rare sense of unity and consensus in our effort. If there is one issue, on which we are even more unified than all others, it is that the horrors that are inflicted on our wounded service members and their families in the name of the physical disability review process, known in the Department of Defense as the MEB/PEB process, simply must be stopped.

It should not surprise you that each part of the governmental process can make sound arguments to defend and explain why three, and in the case of the Army, four separate Board proceedings – with associated paperwork demands on the wounded service member and family, accompanied by delays and economic dislocation for assisting family members, and characterized prominently by inexplicable differences in standards and results – are justified. We, however, are a Nation which values the every day good sense of the common man or woman – that is why we call it common sense. And, common sense says that from our service members' and families point of view this must seem a wildly, incomprehensible way to settle for service members and families the question of whether the member

must leave the service and, if so, under what conditions. We recommend one combined physical disability review process for both DoD and VA.

Virtually every finding and recommendation we make can be traced to these four concerns: (1) leadership and attitude; (2) the transition from Walter Reed Army Medical Center to Walter Reed National Military Medical Center; (3) the extraordinary use of IED (improvised explosive devices) in the current wars and their impacts on the brains and psyches of our service members; and (4) the long-standing and seemingly intractable problem of reforming the disability review process.

To be sure, it was the degradation in facilities that first caught the eye of media reporters. Important as that is, however, we believe that there is far more to be dealt with here than applying paint to rooms or even crawling around basements to deal finally with electrical problems.

None of these concerns, however, is our bottom line -- not BRAC, not facilities, not even the search for failures, breakdowns, or culprits. Rather our bottom line is this:

(1) We are the United States of America.

(2) These are our sons and daughters, brothers and sisters, uncles and aunts, even a grandparent or two.

(3) Their families are our families; we are their neighbors, and we, their fellow citizens and residents.

(4) Their anguish is our anguish.

(5) We can and must take care of them…we must do better than we have thus far.

Secretary Marsh, have you comments you would like to offer?

Secretary West, thank you. Yes, I would like to offer a few points. Mr. Chairman, Mr. Shays, distinguished members of this Committee, I join Secretary West in thanking you for this opportunity to bring to the Congress our concerns for the wounded and sick service men and women and their families.

I am a World War II veteran, a retired Virginia National Guard officer and a former Member of Congress. Two of our sons served in combat in the Persian Gulf War. The oldest, a combat surgeon, was later severely wounded in Somalia.

There is a national ethic: America always takes care of its wounded. We must ensure that we, as a people, continue to emphasize that ethic.

While not to diminish the role of the active force, we must remember and understand the hardships placed on our Reservists and Guardsmen by calling them to duty; they have special needs and we must be mindful of those needs.

Families! The men and women who serve – whether from the Active or Reserve components – have families who need our help, particularly when their husband or wife or child becomes wounded. We must help them.

As Secretary West so eloquently stated, many factors contributed to the "perfect storm" that brought Walter Reed Army Medical Center to our

attention. We must look to the systemic issues and fix them so that we can abide by our American ethic and take care of our wounded and their families. The remedies to the problems associated with the medical community, including those within Physical Disability Evaluation System, are not confined to the Department of Defense. Servicemembers and veterans are also going to need the help of the Department of Veterans Affairs, OMB, and OPM to fully address all the facets of this problem.

We have reason to think that some of the observations in our report are systemic. Although we were charged to look at Walter Reed and, to a lesser extent Bethesda, we did encounter indications that some of the problems do exist in other military medical facilities of our Armed Forces.

Ultimately, it is the Congress that can address and fix the shortcomings that exist in our medical services in order that members of Armed Forces can receive the care they deserve. You have the authority under the Constitution to raise and maintain the forces, including Militia, necessary for our National Defense. This will require commitment and perseverance to achieve, but it is vitally important. I am confident you will rise to the challenge.

Thank you.

(Mr. West's speaks) Mr. Chairman, Secretary Marsh and I, as well as the other talented and experienced members of the IRG with us today, would be happy to respond to your questions at your convenience.

Thank you.

Mr. TIERNEY. Thank you both very much for those opening statements.

We are going to proceed to the question period under the 5-minute rule. I am going to begin. I suggest that whoever feels best qualified to answer the questions so select down there on that, or I will leave it to the spokesperson if you want on that.

I noted under both your comments on that and in page 6 of your testimonies that you recommend one combined physical disability review process. That is the crux of much of what we are talking about for both the Department of Defense and the Veterans Administration.

To whom should we look to be held responsible to make sure that gets done?

Mr. WEST. My recommendation, Mr. Chairman, are the Secretaries of Defense and the Secretaries of Veterans Affairs. They have the rulemaking authority for their two Departments and can probably solve that. To the extent that it requires any legislative adjustments, then, of course, that is your bailiwick.

Just one example. In the Department of Defense, if you are a member of the Army and you are eventually going to end up leaving the service because of medical difficulties you have encountered, the wounds, whatever, you can face four boards to consider your physical evaluation, your disability, before you even get to the VA. That is because there is one that determines whether you will remain in your MOS. Well, that is four including the VA. One determines your MOS. Then there is the medical evaluation, the physical evaluation, and then, of course, there is the DAV's Board. When you look at the larger picture, they are all deciding two issues: one, will you have to leave your current duty, and, if so, under what circumstances.

Now, I understand that there are many analyses that can show the other different aspects, but that is what it boils down to, and for service members that is very difficult.

Mr. TIERNEY. Thank you. I would assume, and you probably don't have to answer, that is going to work fine if the Department of Defense and Veterans Administration Secretaries understand that somebody at the White House wants an answer and wants to ride herd on this thing, so I accept your answer, I think it is excellent. They can suggest legislation to us. They can make the rule changes on that.

But I would just add the caveat that I assume that this only works if somebody at the White House is making sure that both those Secretaries know that somebody has to answer the bell and get that work done. It is not going to be enough to swallow, it is not going to be enough to do it in silos; it has to be a cooperation.

Mr. WEST. Yes, sir.

Mr. TIERNEY. What is the estimated time that we should be looking for them to complete this implementation? I think it is going to be a large task on that, but not one that we can let linger, so this committee likes to set time lines for continued hearings to sort of keep the process going here. What would be a reasonable time for us to expect those Secretaries to have that done?

General ROADMAN. Mr. Chairman, I am Chip Roadman. I am a former Surgeon General of the Air Force.

I think re-engineering the system, putting it at a year is probably a reasonable issue. Common sense would say but there are going to be people who are going through this system for the next year. Actually, one of our recommendations was that every one of the disability determinations, from 0, 10, 20, less than 30, from 2001 to the present should be re-evaluated to be sure that there is consistency and that there is fairness in the decisions, in addition to all those that were discharged under the existing prior to service.

Mr. TIERNEY. That is what you would do in the interim?

General ROADMAN. That is what I would do in the interim.

Mr. TIERNEY. And you would have one group do all that evaluation?

General ROADMAN. Yes, sir.

Mr. TIERNEY. Who would that be?

General ROADMAN. I think that a group of people who really understand the clinical issues, as well as the rehabilitative issues that our servicemen have to undergo should be appointed to do that.

Mr. TIERNEY. And that would be for both the VA and for the DOD?

General ROADMAN. It probably would be, sir, but it would be a significant group of clinical records to review and is a mammoth task but should be done.

Mr. TIERNEY. Thank you.

General JUMPER. Mr. Chairman, if I could just add, for one moment.

General JUMPER. At some point during this continuum of care, which is what we call it in the Corps, unbeknownst or unannounced to the wounded soldier or Marine the system turns from one of tremendous advocacy, and you have heard the testimony about getting people off the battlefield and into primary care in record time, performing virtual miracles keeping people alive, but at some point this continuum of care turns from one of advocacy, profound advocacy, into an adversarial process.

The point of view of this single process needs to be from the point of view of the wounded warrior and not from the point of view of the bureaucracies that look down on the wounded warrior and make the processes more comfortable for themselves. It has to be that of the warrior, and be able to streamline, from the point of view of the soldier, Marine, airman, sailor, the expeditious way through this process. That is the point of view that has to be taken.

Mr. TIERNEY. Thank you.

I notice that the yellow light is on. I am going to move on. We may come back for a second round on this, so I don't want to keep any of our other Members from that.

Dan.

Mr. BURTON. Thank you, Mr. Chairman.

You mentioned the wounded warrior. I had a young man from my District who was severely wounded, and he went to Walter Reed and received very good treatment. He went back home and he has to come back for additional treatment on a regular basis, but one of the things, he is still on active duty, and so he was being

required, even though he was almost completely blind, to come back and stand with his company on a regular basis.

Now, I called out there and talked to the company commander and he said, well, we will try to arrange for him to stand with a company in Indianapolis so he and his wife don't have to get on a plane and come out here and stand for just a few hours and then go back. I just wonder if any other personnel are experiencing that, because it doesn't seem logical to me, if somebody is severely injured, they have been treated at Walter Reed, to go home and, unless they are coming back for treatment, come back and forth and back and forth just to stand with their company when they are called out for regular order. It doesn't make any sense.

I just wondered if that was addressed at all by this. I mean, it is something that is not necessarily directly connected, but it seems to me something that is very important.

You talk about treating the wounded warrior very well. This is one of the things that should be done. They ought to take into consideration not only his condition and what they have to do to make him whole, or whole as much as possible, but also try to make it as convenient for him as possible to get to and from and do the duties that he has to do while he is still on active duty.

Major HOLLAND. Sir, it is very much appreciated for you to bring that up, because, as the NCO on this group, non-commissioned officer, it is my job to look out for those folks. I have to tell you some of the things you will hear as we try to get our wounded warriors back to their units and back in formations at times. Secretary West brought up the idea of using common sense. Somehow we have lost some common sense. That is not the way we should be treating these wounded warriors that are on very strong medication.

Now, yes, we do need to keep accountability of them, we need to keep track of them. No doubt about that. For PTSD, TBI, we need to do even a better job, sir, of keeping track of them.

Mr. BURTON. Well, in this age of computers and the way we keep track of almost everybody any more, it doesn't seem to me very difficult to say to a wounded veteran, you can go to a unit in Indianapolis to make sure that your attendance is shown. But this guy is almost 90 percent blind, and for him to come back to Washington requires his wife to come with him, they have to get a place to stay, then they have to go to his unit, then they have to go back to Indianapolis or back to the district. He is outside of Indianapolis. That didn't make sense.

Major HOLLAND. Sir, one thing to add to that if you will, that individual may look at community-based health care, because we have CBHCOs in a lot of the areas that they can go under.

Mr. BURTON. Well, in his case he still requires treatment at Walter Reed, and he has been getting good treatment. The problem I am talking about is this unnecessary travel.

Major HOLLAND. Yes, sir.

Mr. BURTON. And I hope you will look into that for others, because this is probably not an isolated case.

One of the things that I noticed in your report, it says "Create a recruiting and compensation plan including a review of the military service obligation should be pursued to address health care professional staffing shortages." I had a conference yesterday and

had about 400 veterans there in Indianapolis, and we talked about Walter Reed, and Bethesda. We talked particularly about the treatment at Roudebush Hospital in Indianapolis and the hospitals at Fort Wayne and in Marion, IN, and one of the problems they talked about was getting treatment in a relatively quick fashion when they needed it, among other things.

I noticed here you were talking about having a problem in attracting health care professional and staffers, people on staff. Do you need more money for that? Is it a logistical problem? What kind of a problem are we talking about here?

General ROADMAN. Sir, I'm Chip Roadman. The money is an indirect issue, and that is you have to have the ability to hire. In other words, if you have the money but it is not competitive in the marketplace and you can't hire, then that is essentially not having the money.

Mr. BURTON. If I might interrupt, I apologize for this. It seems to me in time of war, when we have young men and women coming back who are suffering severe injury, that whatever it takes to make sure we hire the best personnel possible, even for a short time, ought to be done. And if additional appropriations are needed for that, I hope somebody will tell us what is needed so that we can make sure that, if there is a shortage of nurses or doctors in a given field, we can cough up the additional funds to make sure they are there to take care of those guys.

General ROADMAN. Of course, as you know from our report, we identify high expense marketplaces where, in fact, the pay grade needs to be higher in order to be able to hire people. But your basic point is almost as if you had been on our review panel, and that is: if you are at war, and our view in many ways is that our bureaucracies have remained at peace while the war fighters have remained at war, and so we see the processes and the ability to have other than business as usual as the way to get things solved is one of the inherent issues that we have.

Now, if I might, you took the easy patient with the active duty patient without sight. You have to think in terms of, as we look out in the system, the Reservist, the Guardsman who is separated not with retirement and goes out into their local area, and it may be a very rural community where that health care is not available. In fact, our system disconnects from them and they are on their own.

I think that there is a fundamental flaw in how we design our systems to take care of individuals wounded in war in that we have a lifetime obligation. It is the cost of war that I believe is there. There is a moral and a human cost, and it can be costed fiscally, as well, as a tail that has to be calculated in cost. When we put force on force, we need to be willing as a Nation to stand up and accept that.

Mr. TIERNEY. The gentleman's time has expired. Thank you.

Mr. MARSH. Mr. Burton, there are 94 nurse's vacancies at Walter Reed Hospital, and you can't fill them because they are not competitive because they are only permitted to pay in the pay scale directed by the Office of Personnel Management, which was set up in 1972. They have tried to give them some leeway, but it is so far below the going rates for nurses in the Washington area you can't fill the vacancies.

Mr. BURTON. Mr. Chairman, let me just say I know my time has expired.

Mr. TIERNEY. It has.

Mr. BURTON. This is critical.

Mr. TIERNEY. It is critical, and I would just ask the Secretaries, would we not expect the Secretaries to make a recommendation to Congress for adjustment of funding for just that purpose so we wouldn't be waiting here so many years later to catch up?

Mr. Welch.

Mr. WELCH. Thank you, Mr. Chairman.

I want to thank the members of the panel for your great work.

There is a lot of discussion about the disability review process, that it is incredibly complicated, and you have addressed that. Professor Linda Bilmies from Harvard has made a recommendation to try to simplify that by doing something such that there would be a rating based on a scale, and you get a one, two, three, four, or five. You would make that determination. It would be a simple thing to do. Then the Department would audit these going back to see whether those determinations, in fact, were consistent with standards. That is the accountability.

It makes a lot of sense to me. My question is whether it makes sense to you.

I would maybe start with you, General, because I thought that the point that you made is really true. You go from advocacy to an adversary situation. To some extent that is endemic in the entire medical system, whether it is in the VA system or it is in the private health care system, because, no matter what, it is extraordinarily confusing, so finding some practical way to simplify and take the complexity out of it to me sounds like an excellent recommendation that you made, so I would be very interested in making improvements.

General JUMPER. Let me start, and then I will call on my colleague, Chip Roadman, who really dove into this.

My observation is that this process could be extremely simplified, and I don't think it would take a lot of work. But when you get down into the regulations and the rules and you look at, for instance, the coding process that is required by these outdated regulations to be used for traumatic brain injuries, then you quickly get these people classified in a way that is completely out of step with what their true injury is. And it is all caused because the coding system, the deliberative coding system, has not been caught up to date, brought up to date. We are actually subject to printing cycles to update these regulations.

One of the things that didn't get into the report that is, I think, badly needed is a way to update the medical community on some of the cutting edge things that are happening out there. At Bethesda there is a very forward-leaning diagnosis and treatment protocols that have been advanced for TBI, but it is not promulgated system-wide. We need something like, in my business, the FAA bulletins that are put out for aircraft discrepancies that are immediately put out to the community, adjudicated by a scholarly board that has authority over this and gets this out to the communities right away, something like that, along with a simplified rating process that you mentioned, sir.

Mr. WELCH. Thank you.

General JUMPER. Chip.

General ROADMAN. Yes, sir. I think what you are describing is an occupational medicine approach to if you lose a hand you are compensated X amount of money, and that is a civilian type of a model.

That clearly is easy to implement. The real problem comes down to we took Johnny out of his community and we returned him not in the same condition that we got him, and he is no longer able to do the occupation that he was trained for.

Mr. WELCH. Yes.

General ROADMAN. And so if you are actually discharged or don't get a retirement, you are not eligible for the health care. You get a severance pay, and that generally is not a livable allowance. So there is an issue with how well compensated the warrior is as he comes back into his community.

We said the real measure of success was that if his mother thought he was treated fairly, that probably we hit the mark. That is hard to put into bureaucratic measurable programmatic terms.

The issue that we have been talking about on coding is one where PTSD and mild traumatic brain injury seem to be signature injuries of this war. There is not an obvious civilian analog to this, in that brain damage that is seen in our emergency rooms every day is due to acceleration and deceleration injuries, coup contrecoup within the calvarium.

The problem is that what we are seeing with TBI, mild and not penetrating head wound but mild, is due to over-pressuring from a blast injury and is an invisible injury and, in fact, is hard to diagnose because it overlaps with PTSD. They are in the area called attributable diseases, which you take symptoms rather than findings, and we are out beyond what we now clinically know, and we need a tremendous amount of research.

Now, all of us are very quick to say we need quick research, at least getting to the 80 percent answer and not necessarily this grinding peer-reviewed type of scientific study that we have the answer 20 years from now and then have a cohort of wounded soldiers.

So I think the issue is that we clearly need a way to track and identify. What General Jumper was taking about, in the civilian coding of medical records there are about 19 codes that could be mild TBI. If you put that through the ICD–9 codes and then you come back through the DSM-IV to try to actually finally—this is more technology than even I understand, so I hope you don't pin me down on this, but what happens is those come out as psychiatric disease rather than a neurologic injury. That is not what our scientists can do either retroactively or prospectively to define the cohort that we need to study to get the answers.

So what we have found as we pulled the thread, it attaches to everything else.

Mr. TIERNEY. Thank you. The gentleman's time has expired.

Mr. WELCH. Thank you.

Mr. TIERNEY. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman.

I would like to ask you gentlemen your opinion about the need. First off, do you agree the challenge is primarily outpatient as opposed to inpatient? Second, I would like your opinion about what you think about an ombudsman, someone to just be assigned to the soldier for years, if necessary, at least in wherever location they are.

Mr. WEST. Well, the answer to the first one is clearly yes. The problems are in the outpatient as that applies to Walter Reed and other areas. That is where we focused, that is where it arose. That is not to say that in our course of reviewing things we didn't come across some ways in which there could be other improvements, but the problem is in the treatment of the outpatient, the group that are going through rehabilitation and the process for the physical and medical evaluations, as well.

Mr. TIERNEY. Is that agreed by all of you?

Mr. MARSH. Yes.

Mr. FISHER. Yes.

Major HOLLAND. Yes.

General ROADMAN. Yes.

Mr. SHAYS. Do you have an opinion as to why the system broke down? Or did the system never work properly when it involves outpatients?

Mr. WEST. I think everybody on the panel—who wants to start?

General ROADMAN. I will start on that. Health care generally is taught and oriented in an acute care inpatient setting. What we are talking about is rehabilitative care, which is fundamentally different from acute care. The only reason I think this came up is that the system was stressed by the volume of patients. The system will work today by bailing faster, but as you get more and more patients the system actually has to be fixed.

There are three ways we need to look at health care: prevention, acute care, and rehabilitation. Our job we are talking about now is taking Johnny back to his community able to re-engage in life, and that is different from the acute care that we normally deliver.

Mr. WEST. You raised a question of an ombudsman, Mr. Shays. I wonder if the Sergeant Major might say something on that.

Major HOLLAND. Sir, the service member certainly needs an advocate, but they need an advocate that is schooled enough to be able to help them walk through the mine field that they have to walk through.

Now, we talk about the ombudsman, but we also talked about the rating system. Let's make sure that no one gets service concern. The services still should have the ability to say whether or not I am fit for duty or not fit for duty. Once it is said that I am not fit for duty and I go in that other category, then I ought to go to the disability system, and that is where I really need an ombudsman.

We talked about case workers. We talked about case managers. But with a load of 30 and 40 to 1 they are not given a good, positive situation.

Earlier you brought up legal staff. Three legal folks at Walter Reed is unacceptable. I talked to the head of the JAG. They tell me that there are five Reservists, legal staff, coming in that will be there for the next year or two. We need certainly more advocates

for the individuals to understand what their rights are and to make sure that they get treated fairly every day, sir.

Mr. SHAYS. Thank you.

If you would all describe to me the differences of what you saw at Walter Reed versus Bethesda.

General ROADMAN. Sir, I am Chip Roadman. There was a significant difference between the two. Bethesda had reorganized their patient care as a team so that very holistic health care was delivered per individual. In other words, if someone had an orthopedic injury and a soft tissue injury, they didn't have to go to two physicians at Bethesda. They had a team approach to that. At Walter Reed what we found was that the disease were treated by organ systems, primarily, sequentially rather than in parallel. We made that point in the report, saying that was one of the really best practices that we had seen.

Mr. WEST. There are some other differences that come out. First of all, of course, the numbers at Walter Reed exceed those at Bethesda. What that means then is that when you are talking about folks who can function as an ombudsman for, say, service members and families, Bethesda had theirs covered. The Marines who are there are well helped in making their way through the process and also through the regulatory procedures. That wasn't happening at Walter Reed. That is the impact of the ratio to case worker, the ratio of patient to those who can help them through the process.

The Marines take their folks the minute they get off the plane, in fact perhaps even before the plane that comes in, and has someone assigned to be responsible for that serviceman through the whole process, all the way back to their wounded warrior barracks on either coast. The Army folks at Walter Reed just don't have enough people to see that that happens.

Now, in some cases it does. Special Forces are there from the beginning to sort of follow their people. But the fact is numbers can make a difference and did make a difference there.

There are some other things. The Navy does its facilities maintenance at Bethesda much better than the Army does it at Walter Reed. Now, is that a service tradition that the Army fighting in worse conditions somehow lives in worse conditions? Even if it is, it is no way to treat the wounded. But the point is you can notice those distinctions, and they make a difference in what service members and their families experience at those two facilities.

Mr. SHAYS. Thank you very much.

Mr. TIERNEY. Thank you very much. The gentleman's time has expired.

Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

I would also like to thank the panel for their work and their testimony, and I would particularly like to commend General Jumper on your comments about the nature of the relationship toward the soldier throughout the system. I think we can all agree that the focus ought to be on the soldier's welfare from beginning to end.

I have a question about resources. During the initial hearing we had, I and others on the committee continued to ask those in charge at Walter Reed whether resources, namely financial resources, were part of the problem, and they kept saying no, no, no,

which I don't think that made sense to many of us because there was so much implied argument to the contrary.

I know you have mentioned in your report that resources were contributing, a lack of resources contributed to the problem, so I would like you to comment on, first of all, the notion of the efficiency wedge, what that is, because I know that was mentioned in your report, and how this might have adversely affected care, and also why you think there was denial of the fact that resources were part of the problem.

Mr. MARSH. Mr. Congressman, the resource methodology is very difficult to understand for the medical community in the Department of Defense. It has undergone a very significant change some time in the last 15 or so years, where the funding is taken out of the service, either Army or Navy or Air Force, and is moved up to Defense Health Affairs, and then the funding will be allocated at the Defense level without review or input at the Secretariat level of the three services.

I think some of this is done because it is thought to be more effective, but I am not sure it is working out here in the time of war.

Out of this comes what are called wedges, and either Admiral Martin behind me or General Roadman can tell you better, but the wedges come down to the service. They may tell the Army medical community your wedge is $42 million, which means that you have to find that $42 million in your whole total community and the answer is you will find it in efficiencies. You often can't find it. And the last wedge I think that came down I think was $142 million, and I believe the Surgeon General indicated there was no way he could execute that. In the previous wedge, to protect Walter Reed, they kept them out of the wedge. The wedge means a wedge into your medical budget that comes back up to Health Affairs.

Chip, do you want to speak to that?

General ROADMAN. Yes, sir. Chip Roadman.

The wedge is a formula applied to workload that is retrospective. As your workload goes down, it is assumed that your costs go down in a formula relationship. I call that the death spiral of health care, because as we mobilize critical skills and send them into the theater of combat, those skills are no longer available within the treatment facilities at home, and the workload of course will go down. The problem with that logic as you extend that out is you ultimately end up with only a deployable medical force with everything else being bought in the civilian sector. I don't think that is where we need to be going as a military health care system.

You know, I hate to give you a flip answer, but the efficiency wedge is a death spiral.

Mr. WEST. Sir, it can also be very misleading, Congressman. Having overseen two Departments, I can tell you that the wedge goes in and you are given inducements to meet it. You meet it or you don't, but if you meet it, having accepted essentially that percentage cut in your budget, you are rewarded by having the budget the next fiscal year set at that level with a new wedge.

General JUMPER. Sir, may I add there is also a stealthy dimension to this as far as resources go. A lot of the resources that are put against the immediate problem, for instance, at Walter Reed, come from other areas of the budget, the line of the Army that

come in there to do and pick up some of the slack that was identified in the Washington Post and other places. Eventually, those functional areas from which those resources came—that is money and people—will be asked to go back to those functional areas. Unless they are institutionalized, they stand a good chance of evaporating when the immediate crisis evaporates. That gets to the recommendations in our report that talk to institutionalizing and some strong oversight to implementing the measures that are written in the report.

Mr. TIERNEY. Thank you. The gentleman's time has expired.

Mr. Hodes.

Mr. HODES. Thank you, Mr. Chairman.

I want to also thank the panel for your good work on this.

I have two areas of questions. The first concerns the office of the ombudsman. I asked my office to send me some information just to check. I want to make sure that the panel is aware that Congress recently passed the Wounded Warrior Assistance Act of 2007, and I have not matched up what we passed with your recommendations, but I would urge you to take a look at that. I don't know how the timing worked with your study and that act, but I think we really probably need to take a look at that in light of your recommendations, and any help or guidance you could provide Congress on that I think would be helpful.

One of the things that the act did was it set up an office of an ombudsman in the Department of Defense. Section 102 of the act sets up an overall office to coordinate, as I read it, other offices of ombudsmen in the various military divisions.

I am hearing that, while the Navy and the Marines have done a pretty good job with somebody, some office, some way to coordinate all the benefits, care, and services that may be available to the wounded warriors on that side, the Army has not. So one of the things it sounds like we need to look at is making sure that there is specifically an office of the ombudsman, and perhaps at each medical facility, whose duty is to the soldier and their family, not to the armed services so much but to the soldier and their family, their duty runs to them to help them coordinate what they are going to have to go through. Is that, as a concept, something that you agree with?

Mr. WEST. Mr. Hodes, the answer is yes. I think that Command Sergeant Major Holland has already indicated, and his indications are certainly those of the panel.

In fairness to the Army and to Walter Reed, much has changed since we did our review, and they have, in fact, addressed the case worker issue, the imbalance, reworked the numbers, and so you will hear, I think that they have made an effort to address it.

Whether the case worker does what the act requires is another matter to be looked at. Certainly from our perspective the need for some advocate who can help guide individual service members and their families through that time when the service member cannot be expected to be thinking clearly, when the family is tormented by anguish and concern, is one that we think the Army is trying to meet, but certainly what you have mentioned in the act also seems a way to be helpful.

Mr. HODES. My concern is amplified by a meeting I had with a constituent at home recently. I met with the soldier and his wife who was at Walter Reed. He described a similar story to that which we heard when we were there for testimony, you know, having to navigate 14 different signatures to have somebody say what he already had been told, which is he is blind in one eye, half blind in the other, his arm is busted in 13 places; having to show up for formation when he could hardly stand, with nobody to go to to help him, a case manager who seemed more interested in telling him what he didn't need than what he did. So my concern is very personal to me with that constituent.

The second question is perhaps briefer. General Jumper, I listened with interest when you talked about essentially an attitude issue. The same constituent that I met with described a suck it up soldier attitude to what he was dealing with. I don't think you can legislate attitude. How are we going to change the mind set from suck it up soldier to these are wounded patient soldiers who need our care? How are we going to change that attitude, because I don't think we can pass an act that would do it.

General JUMPER. Sir, I think that is a very good question. Indeed, it is the tradition of all of our military services to, as you say, suck it up. That is the way we look at things. I don't think the American people would want it any other way.

However, when you transition yourself into this sort of an environment where you now involve families and loved ones, and, indeed, in a process where the families and loved ones are necessary to be able to coordinate all of the activities of our more severely wounded warriors, then that is when compassion has to take over for a little of the suck it up attitude.

I think everybody agrees with that. I think everybody agrees that it was probably a bit overboard in that direction. I know that the commanders that we have talked to have instituted steps to correct that, to pay more attention to the families and to the loved ones.

Mr. TIERNEY. I thank the gentleman. His time has expired.

Mr. Braley.

Mr. BRALEY. Thank you, Mr. Chairman.

Quite frankly, General, telling a patient suffering from post traumatic stress disorder or traumatic brain injury to suck it up is counterproductive. Isn't that correct?

General JUMPER. Yes, sir.

Mr. BRALEY. And one of the problems that we have sitting up here is that when we had our first hearing at Walter Reed on March 5th I asked General Schoomaker, General Cody, and the Acting Secretary Garon if any of them could tell me how many patient advocates were serving the patient population at Walter Reed, because the Post article indicated not only were case managers being added to the population, but also patient advocates. You know what they told me? None of them could answer the question.

I made a request at the end of that questioning for a clarification on what the number of patient advocates were, because it is contained in the Wounded Warrior Assistance Act. It is contained in your independent review. And nobody has answered my question. So when you want to talk about the frustration of inaction, it is on both sides of the table here.

One of the things that we have to do is get back to the point of view you talked about. One of the recommendations you made in your report has to do with employment assurances. My brother works at the VA Hospital in Knoxville, IA, which has been on a yo-yo for 10 years on whether they are going to close the largest VA hospital in Iowa, spend $260 million of new facilities management and move them to Des Moines, and they are losing their best employees who are going to other VA facilities around the country because no one is giving them that assurance. This is an endemic institutional problem that has to change, and you have to be the voice to make it change, because, quite frankly, we are not getting a lot of answers on this end.

One of the things that I think that is very important is you raised the point, General Roadman, about what is the cost of war. You have talked in your report about the advancements in medical care that are changing many former fatalities into wounded warriors with injuries that are, frankly, going to cost us staggering sums if we invest the money we should to take care of them.

If you look at a life care plan for somebody with a traumatic brain injury or PTSD, the average life expectancy of a 19 year old male, according to the U.S. life tables, is 57 years. You cost that out. It is a lot more than your $100,000 DOD death benefit. Yet, we are not getting any information from the administration on what the long-term consequences of health care are for the casualties of this war. You have to use your platform to be an advocate for that, because that is a hidden cost that nobody is talking about.

One of the things that was also frustrating to me is one of your recommendations deals with promoting education and research in prosthetic care, production, and amputee therapy, and we heard very compelling testimony about people with multiple amputations going back to active duty performing valuable functions as active duty personnel, and yet we know when we are dealing with the rampaging cost of long-term health care that if we want them to be active throughout that 57 year life expectancy and not be a burden on our health care system, we have to invest in the type of prosthetic care that keep them active and functioning. Yet, if you look at those DOD reimbursement schedules, they provide initial prosthetic care and then they are left to fend for themselves.

So what I want to emphasize is your value to this country in keeping this topic front and center, because we can have hearings until hell freezes over, we can pass the assistance act, but unless the military and Department of Defense do something to act on their recommendations nothing is going to change.

Female SPEAKER. What if you stop funding war?

Mr. TIERNEY. Excuse me 1 second. The witness will suspend, please. We have been more than, I think, lenient with what is going on here. Now I am going to ask that you sit down and not disrupt the room. As long as you are quiet and you don't disrupt other people and you don't get in the way with their hearing of this witness, this hearing, we are perfectly fine. There are people sitting behind you who want to watch the proceedings, people who want to listen to it, so I ask you to keep your comments to yourself, keep in your seat, and you will be just fine.

Otherwise, we want to be respectful of what is going on here, about the people who are returning from Afghanistan and Iraq that we all have great concern for, including you. We appreciate that concern. So please work with us. We have been as lenient as we could. Now we expect that you are going to stay seated and stay quiet. Thank you.

The witness may proceed.

Mr. MARSH. That was a very timely and powerful statement you just made.

Let me mention something to you that I am afraid the Congress is going to overlook, because we had a tendency to overlook it. There are statutory differences between the National Guard and the Reserves and the active force. Those statutory differences, unless they are identified, in the process of treating the wounded can have some very significant consequences.

For example, if the National Guard or Reservist soldier goes off of active duty when he returns home with his unit, if he goes back to his unit and is mustered out, his chances of being able to get back into the system are extraordinarily difficult and very hard for him to achieve. I don't think that Congress is looking enough at these two very important distinctions in the service. And there is a difference between Reservist and Guard, too. But the point you make I'm sure was not lost on all these military people sitting here behind me, but you are quite correct.

General ROADMAN. Mr. Braley, I absolutely agree with you on the hidden cost issue. After leaving active duty, I represented nursing homes and assisted living in the District here with the American Health Care Association, and I understand fully what the lifetime costs of rehabilitation care and care for people with chronic diseases are.

We have had some interviews, and the question was, well, who do you think is going to pay for these recommendations? The panel generally has taken the position of actually that is not our problem to fix. Our problem is actually to point out the remaining gap for the people who serve our country, and we recognize the cost is immense and it is our moral obligation to address those issues. As we engage in force on force, recognize that it is not just bullets, it is not just weapons systems, it is also the tail programmatically of people who are wounded in defense of our country.

I would like to add one thing quickly. We have talked about wounded warriors. One of the things that we have seen going from facility to facility is people saying, wait a minute. I have been injured and I am not a warrior. It wasn't in Afghanistan and it wasn't in Iraq. The fact of the matter is what we are talking about is service members, regardless of where they were wounded, they need the same standard of care, the same standard of access, and the same standard of respect and priority.

I don't want us to fall into the trap of saying this is for "wounded warriors" and therefore limited to particular operations. This is an all volunteer force. We have obligations to take care of them.

Mr. TIERNEY. Thank you, General.

The gentleman's time has expired.

Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair, and thank you, gentlemen.

Mr. Marsh, you are right. We are not doing our Reservists and our Guards and our active duty members any favors by having compensation and everything being so jumbled and such a mess when they come home, because they all talk to one another, they all live in the same communities, they all served in Afghanistan, Bosnia, Iraq, with great honor. To come home and find out that they are treated differently when they worked and served and stood in harm's way is a huge, huge disservice to the sacrifice and the commitment that they and their families made, so thank you for pointing that out. I look forward to correcting those inequities, especially as our Guards in Minnesota have been now extended. The second wave just got extended an additional 4 months.

My concern that I am coming with is the seamlessness between the DOD and the VA, and, where appropriate, maybe DOD people who would still be covered by DOD might be more appropriately receiving care in a VA facility. It should be seamless. It should function in a way that really takes care, puts the patient first.

So I am concerned when I see that the focus on Walter Reed and Bethesda, which I think needs to be because of the current problems we had, but I think your panel needs to be looking at the VA system, the outreach that we have in community rural health services, how we take care of our soldiers when they come home and their homes need to be refitted in order to accommodate a wheelchair, accommodate a walker, accommodate kitchens so that they can be active not only in their communities but in their homes, which helps toward healing.

So my question to you is going to be, what do we need to do—and I met with my county Veterans Service officers who are great, wonderful people, but they are all close to retirement. What are we going to do to make our Government live up to its obligations, to be advocates for families, to have case workers and ombudspeople, as well as county Veterans Service officers? They all have very separate roles.

What I am concerned about, just as we have people mixing up what the Guards and the Reservists and what the regular service members are entitled to and people not understanding the differences in that and correcting it, I am also concerned about making sure that case workers are given their jobs to do, which are very different than what an ombudsperson does, very different than what a county Veterans Service officer would do. Who is going to track and provide that seamless integration between DOD and VA, and who is going to make sure that we have all the different layers of paraprofessionals available and that the ombudsperson truly is independent?

Let me give you an example of where I think we are failing already. DOD has someone assigned to the VA hospital in Minnesota. VA system loves having that person there. DOD tries to keep someone there. That person rotates on an average of every 4 months. How do we, you know, have someone who understands the difference between the systems and really working with someone? Can you address the human need of making sure that we have DOD/VA be seamless in all the different levels of people who works

with patients that aren't providing health care but access to health care?

Mr. MARSH. He's the former Secretary of VA.

Mr. WEST. Congresswoman McCollum, you are absolutely right. When you outlined the problem, you outlined a whole host of problems that need to be addressed, and that we in the panel got to some of them in terms of the seamlessness. We got to the question of the transfer of records back and forth, which is so extraordinarily important to our service members. We got to that question of what had to be looked at in terms of the physical disability review system.

Some of the other issues, in fact, in 45 days we just didn't get to. There is a panel that comes after us. It is already started. I think you know of it, the one chaired by Senator Dole and Secretary Shalala, whose mandate is to look at precisely that interface and in its broadest context as well as in narrow ways.

In terms of the DOD representation at the military locations, you know, even that small presence, that one person is something that is vitally important and that, frankly, a lot of advocates had to work hard to get. As with any agency, but especially with DOD, if there is one person there is a whole history of re-deployments and reassignments in their career. If it is a civilian person, then certainly they could stay longer.

My point is you probably need more than one person, and you probably need it to work. You are certainly right that 3 months, or whatever that period was, is not nearly as helpful as a year. Frankly, from DOD point of view and every other assignment I have ever heard of, you can't even get to know the territory in a year, at least 2 years.

So you make a good point. We didn't address that. We did address the broader issue of seamlessness. And, of course, there is a panel to whom we just reported our findings on Saturday, the Presidential panel, that is going to look at that broader issue.

Mr. TIERNEY. Thank you, Mr. Secretary.

Mr. Van Hollen.

Mr. VAN HOLLEN. Thank you, Mr. Chairman.

Secretary West, Secretary Marsh, thank you for your leadership on this in co-chairing. Thank you to all the others who served on this panel, and for your prior service to our country, as well.

I just have a few comments, and then a question.

First, with respect to the role that the A–76 process played in your findings here, and you state in the report, "The A–76 process had a huge de-stabilizing impact on the civilian work force at Walter Reed Army Medical Center," and indicate that if the military had taken advantage of the waiver opportunities or didn't have to go through the A–76 process we would have avoided at least part of the problem where a lot of attention was focused on A–76, No. 1. No. 2, as a result of A–76 there were lots of people who decided to leave Walter Reed.

I only suggest that I think that problem is endemic not only to Walter Reed but to other Government agencies. AS someone who represents a congressional District right outside our Nation's Capital, I hear regularly from the heads of those agencies—and I include political appointees in that group—who say that this A–76

process has significantly compounded their management problems, the way it has been implemented, not that contracting out doesn't have an important role, I think it does, but the way it has been implemented in a fairly ideological fashion. So I think that recommendation can be generalized to other Government agencies, as well.

With respect to BRAC, as you know, in terms of the BRAC process, you have entered into sort of a discussion that is going on in Congress. Some people have responded to the terrible situation with regard to the treatment of our soldiers at Walter Reed by saying we should not move forward at all with the BRAC process and the transfer. Others have suggested we should push the accelerator pedal and really accelerate it. In your recommendations, you say that you might even want to accelerate or waive the environmental impact statement.

Now, Senator Warner, who is the ranking member on the Armed Services Committee, has said he doesn't want to short-circuit the process. I must say, given that part of the lessons at Walter Reed was the failure to plan in advance for the influx of wounded soldiers we would have, I would think that we would not want to short-circuit that planning process. I think in the long run it will cause more problems for the soldiers who are being treated, as well as the people who have to provide the care, if you rush into a situation without adequate planning, including the environmental impact statements.

Third, I know someone raised the issue of H.R. 1538, the Wounded Warriors. It has passed the House and is pending in the Senate. I am interested in your comments on that, whether you have had an opportunity to review it.

Finally, I was at Bethesda Naval Hospital recently. It is in my District. Talking to Admiral Robinson there, he said one of the issues in discussion—and there is not really a meeting of the minds right now as part of this transfer—is this whole question of medical hold. It gets a little bit to Congresswoman McCollum's comments.

At the Bethesda Naval Hospital they were pretty clear that they tried to push earlier for people to be returned to their communities and provide care through the veterans hospital system. This was an ongoing and quite pointed discussion even as we gather here today with respect to the merger between the two and the different philosophies. Given the fact that outpatient care and the medical hold system is clearly implicated as one of the real problems here, I am curious as to your view of how to resolve that debate.

Mr. FISHER. I am Arnold Fisher. I would like to address the point about the BRAC Commission that 2 years ago decided to close Walter Reed. It is like moving out of your house before you buy a new one. There is no reason why the addition to Bethesda on the third floor, which would create 50 new ICU rooms, can't be done yesterday. I don't understand. We don't need an EIS. You don't need any approvals. You have to have plans made and you need to build it. I still to this point do not understand why that has not been started now.

My problem with all of this is that the one word that has been mentioned a few times today but is not addressed when it comes to fixing Bethesda is that we are at war. This is not peacetime.

This is not a time where we can go through 13 months of EIS approval or to go through 16 months of an architectural and engineering plan. We are at war. We have to address this now. In Vietnam we had three wounded to every dead. We now have 16 to every death coming back. We need to take care of them. We need to have the facility for them. We can't sit around and wait like we would in peacetime and do it in 2 or 3 years.

As far as the EIS is concerned, it is Government land. Waive it. Waive it. I know that the environmentalists will kick and scream, but they are not going to scream and kick as much as these kids that are coming back without arms and legs. They can bring them in. We can satisfy them. This is a golf course we are talking about. You don't have to knock anything down. You can start it. You should start it now, not wait for 13 months for this approval. We should start Bethesda now.

These kids have not stopped coming back. The first day I was on this Commission, Secretary West and I went to Andrews Air Force Base and we watched a C–17 come in with eight stretchers on it. They come in every day except Thursday. These kids are coming back. They are being put in buses, taken to Walter Reed and Bethesda. Now, from battlefield to bed they get the greatest treatment in the world, but the rooms that they go into a 30 year old hospital are as big as closets. Their families cannot get in there to see them. This is wrong. We need to fix it and we don't need to fix it in 3 years, we need to fix it now. We don't have to wait 3 years.

When I first got on this Commission and somebody came from BRAC and told us about the EIS and everything. I hit the ceiling. This is not right, and I want it changed.

Mr. VAN HOLLEN. Mr. Chairman, may I make a comment?

Mr. TIERNEY. Certainly. Go ahead.

Mr. VAN HOLLEN. I am interested, as well, in an answer to the other question with respect to the medical hold, but if somebody told you that the reason—the BRAC Commission recommendation came recently. If someone told you that the reason it is being held up is as a result of the EIS, I can tell you they were giving you a story. That is not what has been holding it up.

Now, what I want to know is if the Commission took a review of the entire BRAC recommendation process. My colleague here, and I am sure you will hear from her, Ms. Norton has pointed out that maybe, if, instead of moving Walter Reed, we spent the time investing in rehabilitating the facilities that you talked about, that you would get the result you talked about. So the issue is there are different ways. I am not going to weigh in to that particular controversy right now, but I don't know if your Commission reviewed in detail the BRAC recommendations and reached a conclusion as to whether or not their original recommendation was the most appropriate in terms of providing medical care.

I happen to think they made a pretty good case, but I am not sure, during your review, I certainly don't see that analysis in this report, a thorough review of whether or not their original decision was right, given the circumstances we are facing right now.

I think every member of this committee feels exactly like you do, that our priority has to be making sure that our people get care,

the soldiers returning get the care that they need. I don't think any member of this committee is going to be second to anybody in maintaining that objective.

So the question isn't whether, the question is what is the best way to do it, and it is not clear to me that your committee had the time or the resources to undertake a full review of the BRAC recommendations.

Mr. WEST. Mr. Van Hollen, if I may?

Mr. VAN HOLLEN. Mr. Secretary, the time is expired but I would like you to respond to that.

Mr. WEST. Thank you, Mr. Chairman.

Mr. VAN HOLLEN. Thank you.

Mr. WEST. I will be brief. You are correct. We are not experts in BRAC. What we are experts in is urgency, the urgency of those who spoke to us, the urgency, as mentioned by Mr. Fisher, but we are not experts in BRAC and we realize that others may make, based on a better understanding, a different choice.

I remember my colleague General Roadman mentioned a minute ago, he said something about cost. He said that is not our problem. Actually, they are our problems, but our mechanism for dealing with it is simply to make a recommendation based on what we have heard and had a chance to see. But you are right, we did not undertake a thorough study of the BRAC process. Others have.

What we have to say is this: there has to be no deterioration of what is happening at Walter Reed as we go through whatever process goes through, because the key thing is the care for these youngsters. There has to be appropriate medical treatment and availability here, at Fort Belvoir, and at Bethesda in such a way as can accommodate that sense of urgency that we have.

But no, we are not the BRAC experts, but we do not claim to be.

Mr. TIERNEY. I thank the gentleman.

Ms. Holmes Norton.

Ms. NORTON. Thank you very much, Mr. Chairman. As a member of the full committee I appreciate the opportunity to sit in and question these witnesses. And I very much appreciate the candor of your report and how rapidly it was concluded.

This committee is singularly interested, first, in stabilizing Walter Reed and other facilities, and then improving them. There is a tendency on this panel, particularly the last lecture that was given by my colleague, Mr. Van Hollen, the lecture to the tendency to conflate what, in fact, has come out of these hearings and out of the Washington Post stories, to conflate two issues: medical care and outpatient care. We are not going to allow that to happen here. We are not going to allow medical care to become a cover for the problem that the soldiers tell us is the problem they have.

The House has not said that there should be no Walter Reed built in Bethesda, no new hospital. The House has said that it is inappropriate in the middle of a war to say that we are going to close a hospital and build a new one. Let me tell you why. We are aware that we are in the middle of a war. We are aware of the deficit that has been built up in the last 5 or 6 years. Are you aware that nobody has appropriated the $2 billion it will take to build a new Walter Reed?

And if you are not, let me tell you this. If, after the testimony we have had here, the House were to come forward with a bill for $2 billion for bricks and mortar rather than putting that money into where the grievance is, in the outpatient system, there would be bipartisan fury, because we haven't had one complaint about the hospital.

I have been into the hospital, sir. I have been into the rooms, and I don't recall any closets. I have talked to patients, as have many on our panel. What we have learned is over and over again now, not only Walter Reed but veterans' hospitals all across the country, we are inundated at not only veterans' hospitals, sir, but veterans' hospitals [sic]. We now have an outpouring of complaints because people now feel they can speak up.

So we have a problem, we in the Congress. When we had our first hearing I asked the generals—there were four of them—I asked them a straight question, has the possibility of the closure of the hospital had any affect on retaining or attracting personnel. To the last general they said yes. If I can quote one of them, Army Vice Chief of Staff General Richard Cody—this is only one of the statements—"We are trying to get the best people to come here to work, and they know in 3 years that this place will close down, and they are not sure whether they will be afforded the opportunity to move to the new Walter Reed National Military Center. That causes some issues."

Your answer apparently is to eliminate the environmental impact statement. If you think that is a problem for the environmentalists, I don't think you understand the Congress of the United States, or dispense with the A–76 process and hurry up the process.

Let me ask you this: if you were in our position, the position of the U.S. Congress, faced with a war we have to fund no matter what happens, faced with the rebuilding Iraq that we have to do no matter what happens, faced with now chronic neglect of domestic issues and pressure from all of our constituents to get to it and to do something there, faced with a deficit that we are committed now to halting and breaking down, what would your priority be? I want the same kind of candor from you that your report shows. If you had a choice between spending the money on outpatient care and veterans' facilities, a new hospital, what would you advise the Congress to do?

Mr. WEST. Congresswoman Norton, I will give a specific answer to the question you just asked. I would advise you to look at the facts that we have gathered, look at the facts that are available to you, look at the allegations of what is good there at Walter Reed and what is not, how the maintenance is, how the rooms are. Look at those facts. Look at the costing of the estimates of what is necessary to be done at Walter Reed to keep it going forward, remodeled, reinvigorated, the facilities fixed and the like. Compare those with the cost of moving to a new facility and doing that, and make a judgment on that basis.

Ms. NORTON. But the $2 billion hasn't even included the cost of equipment, just the cost of putting the bricks and mortar up.

Mr. WEST. I have seen the costs. I have seen a cost workup that was done for another committee. I have looked at that. I tell you that is the way I would do it.

What we are after is one thing, and one thing only: whatever resolution will get the best resolution of two things, one, a need for facilities in which the medical care can be delivered, but also the resolution of the rehabilitation, as well.

Ms. NORTON. Which is the problem before us. The problem before us is the outpatient care, I remind the panel.

Mr. WEST. Right.

Ms. NORTON. The problem before us is not the care at Walter Reed Hospital. To the credit of the hospital, there has not been a single complaint I know of about the hospital. In fact, it remains the premiere military hospital on the planet.

Mr. MARSH. Delegate Norton, if I could add to that—and I know that time is running short—from the standpoint of the Commission, we were tasked with a single task: look at the army medical services, particularly problems at Walter Reed, and, to a lesser extent at Bethesda, which are much, much less. What we were confronted with, I suspect maybe members of the Commission, if we had been voting on BRAC might have had a difference of view, and many might well have agreed with you.

But we were confronted with a BRAC decision, had been accepted by the Congress of the United States, enacted into law, and signed by the President of the United States, so we had to deal with the situation. This is a matter of law and it has been directed by the Congress of the United States that we go forward with it, and so we made our recommendations that were consistent with that.

Mr. TIERNEY. Thank you very much.

I want to thank the members of the panel, as well as the Members here. I think it has been very helpful, and certainly the report that you did was very extremely helpful. We thank all of you, including Admiral Martin, who didn't get to sit at the table on that, but we do acknowledge her work and George Schwartz' work, as well. We have great admiration for the fact that you were able to get it done in such a short period of time and have it be so thorough with the significant respect also for the fact that you dedicated your time and energies to this. We know that you are all busy individuals in your own right, and it is a patriotic and great act of citizenship that you did this, and we thank you very, very much.

That will end the testimony from the first witnesses. The second panel will please take the seats when you get a chance.

Thank you, again.

We will now hear testimony from the second panel of witnesses before us today. Thank you for your patience and thank you for taking the time to be here during the first panel's testimony. I think it would be helpful as we converse here.

I would like to begin by introducing our panel. On this panel we have Mr. Michael Dominguez, the Principal Deputy Under Secretary of Defense for Personnel and Readiness; Major General Gale S. Pollack, the Acting Army Surgeon General and Commander of

the U.S. Army Medical Command; and Major General Eric Schoomaker, Commander of the Walter Reed Army Medical Center.

Welcome to all of you. Thank you for your service to your country and your willingness to be here today.

It is the policy of the committee to swear you in before you testify, so I ask you to stand and raise your right hands. Anyone else who is also going to be responding to questions, if they would please rise, as well.

[Witnesses sworn.]

Mr. TIERNEY. May the record indicate that the witnesses answered in the affirmative.

I am going to provide you the opportunity, if you would, to give a summary of your testimony. As you know, we provide about 5 minutes for that. We would like you to try to stay within that, if you could, and summarize. Your statements will be put in full into the record, and then we would like some time to have a colloquy and some questions back and forth.

Mr. Dominguez, perhaps you could start.

STATEMENTS OF DEPARTMENT OF DEFENSE AND ARMY OFFICIALS: MICHAEL L. DOMINGUEZ, PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE (PERSONNEL AND READINESS), U.S. DEPARTMENT OF DEFENSE; MAJOR GENERAL GALE S. POLLACK, ARMY SURGEON GENERAL (ACTING) AND COMMANDER, U.S. ARMY MEDICAL COMMAND (MEDCOM); AND MAJOR GENERAL ERIC SCHOOMAKER, COMMANDER, WALTER REED ARMY MEDICAL CENTER

STATEMENT OF MICHAEL L. DOMINGUEZ

Mr. DOMINGUEZ. Thank you, Mr. Chairman, distinguished members of this subcommittee, thank you for this opportunity to discuss support and care for our wounded soldiers and their families.

As you know, we have just received the draft report of the Independent Review Group established by the Secretary of Defense. We very much appreciate their work and their recommendations. We will be working to coordinate the Department's review of those recommendations for approval by Secretary of Defense Gates.

We are currently staffing the recommendations of the Interagency Task Force chaired by Secretary Nicholson of the Veterans Affairs Department.

I can't articulate a clear action plan in response to the Independent Review Group findings until our Departmental review is complete and the Secretary has directed action. I would note that the Department has not been waiting for the report to address matters of identified concern.

For example, we have requested an adjustment to the fiscal year 2007 emergency supplemental to provide $50 million so that we can implement in this fiscal year improvements to support and care for the wounded.

The Army has taken aggressive action to make improvements at Walter Reed. I defer to my colleagues at the table to address those actions.

The Office of Personnel Management provided direct hire authority for over 100 patient care positions. As a result the Army made 125 job offers at a recent fair.

Our first survey of wounded warriors and their families is being fielded this month, with results expected in June. We have been working through our Joint Executive Committee, with the leadership of the Department of Veterans Affairs, on improving the flow of electronic information and records between VA and DOD.

I have described our efforts in my written statement.

We are thoroughly engaged in seeking the correct configuration for our disability evaluation system. A joint team of DOD and VA leaders begins that redesign this afternoon. In addition, in partnership with the VA, we are preparing a comprehensive plan to address TBI. The goal is to coordinate our efforts into a comprehensive program of research, education, treatment, and program evaluation.

We are supporting the President's Commission on Care for America's Returning Wounded Warriors, which is taking a comprehensive look at the full life cycle of treatment for wounded veterans returning from the battlefield. We expect their findings in June or July.

In October we expect the report of the Veterans Disability Commission chaired by Lieutenant General Retired Terry Scott. This group was chartered by the National Defense Authorization Act of 2004.

Correcting the fundamental issues underlying our failure at Walter Reed will require legislation. Legislation that addresses root causes, however, will look substantially different than legislation that treats symptoms. We have been working this problem hard for several weeks now, but we don't yet have a clear picture of the legislation needed to correct the root causes. We hope that the IRG's report will help us move down the learning curve there. When we have that picture, we are committed to bringing it quickly to the Congress for action.

Mr. Chairman, I look forward to your questions.

[The prepared statement of Mr. Dominguez follows:]

Prepared Statement

of

The Honorable Michael Dominguez
Principal Deputy Under Secretary of Defense
Personnel and Readiness

Before the

House Committee on Oversight and Government Reform
Subcommittee on National Security and Foreign Affairs

April 17, 2007

Not for publication until released by the committee

INTRODUCTION

SUPPORT AND CARE FOR OUR WOUNDED SOLDIERS

Mr. Chairman and distinguished members of this Subcommittee, thank you for this opportunity to discuss support and care for our wounded soldiers. As you know, we have just received the report of the Independent Review Group established by the Secretary of Defense. We very much appreciate their work and recommendations. We will be working on a fast track to coordinate the recommendations within the Department and develop aggressive action plans to implement those directed by the Secretary of Defense.

As you know, we also await the findings of the President's Commission on Care for America's Returning Wounded Warriors, which is taking a comprehensive look at the full life cycle of treatment for wounded veterans returning from the battlefield. The President also chartered the Department of Veterans Affairs Interagency Task Force on Returning Global War on Terror Heroes. The Department has been actively participating with the Department of Veterans Affairs and the many other agencies in developing the Task Force Action Plan which will be available within the next few days. In October, we look forward to the findings of the Veterans' Disability Commission, chaired by LTG (ret) Terry Scott and chartered by the National Defense Authorization Act of 2004. This Commission is studying veterans' benefits, and is scheduled to report out later this year.

Finally, we requested the Department of Defense Inspector General perform an independent review, evaluating our policies and processes for injured OIF/OEF Service members. The objective is to ensure they are provided effective, transparent, and

expeditious access to health care and other benefits when identified for separation or retirement due to their injuries. I expect to receive the Inspector General report by July 2007.

The intense work being done by all of these groups, as well as that underway within the Department itself, reflect a collective consensus that our existing systems for supporting the wounded need to be examined and improved. Some of them, notably the Disability Evaluation System, are based on laws and regulations that are decades old and don't reflect current operations and realities facing service members returning from battle today. We agree that fixes need to be made.

On April 12, appearing before the Senate Armed Services Committee and the Senate Veterans' Affairs Committee, Deputy Secretary of Defense England acknowledged the need for these changes and proposed three possible approaches:

- As a first step, focus on and seek innovative solutions for the wounded and severely wounded cases, and then turn to the general population of service members.
- Move beyond stove piped data storage systems to create a central data base of information to expedite full electronic information exchange.
- Make existing benefits more accessible through common terminologies and a fully integrated process.

He also proposed that we re-evaluate the entire national system for disability determination and compensation.

The Department of Defense (DOD) is determined to improve processes -- ours and those in which we collaborate or interface.

WE AREN'T WAITING

While awaiting the findings of the Independent Review Group and the other Commissions and Task Force, the Department has engaged in a number of actions to identify issues of concern and fix them. We have requested an adjustment to the Fiscal Year 2007 Emergency Supplemental request to provide $50 million to create a Medical Support Fund to implement any findings or recommendations in which the Department can take action before Fiscal Year 2008.

Walter Reed.

For example, the Department and the United States Army have moved quickly to improve conditions and enhance services at Walter Reed. We have taken steps to control security, improve access, and complete repairs at identified facilities that provide for the health and welfare of our nation's heroes. On March 23, the Army opened its Soldier and Family Assistance Center – a one-stop shop that brings together case managers, family coordinators, personnel and finance experts, and representatives from key support and advocacy organizations in one location. The Soldier and Family Assistance Center reduces in-processing locations from seven to two. In addition, the Army's new Warrior Transition Brigade will be fully operational at Walter Reed on June 7th to assist soldiers assigned to medical holdover. This brigade will reduce cadre-to-Soldier ratios from 1:55 to 1:12.

We can best address the changing nature of inpatient and outpatient healthcare requirements, specifically the unique health needs of our wounded Service members and the needs of our population through the planned consolidation of health services and

facilities in the National Capital Region. The BRAC decision preserves a precious national asset by sustaining a high-quality, world-class military medical center, co-located with robust graduate medical education program, and across the street from the Nation's premier health research organization in the Nation's Capital. The plan is to open this facility by 2011.

In the interim, we will not deprive Walter Reed of resources to function as the superb medical center it is. In fact, in 2005 we funded $10 million in capital improvements at Walter Reed's Amputee Center – responding to the immediate needs of our warrior population. We are proud of that investment in capacity and technology. We simply will not allow the plans for a new medical center to erode the quality of care delivered at the current hospital.

The Army has reported on the recent improvements to Walter Reed living conditions. There are no soldiers living in Building 18. The US Army Corps of Engineers has installed new IT upgrades, phone lines, internet access and cable television for all post lodging facilities. An Emergency Medical Technician is available 24/7 to the Mologne House. The establishment of the Warrior Transition Brigade establishes command responsibility for and oversight over a seamless continuum of care for the wounded or injured.

To provide for robust staffing at Walter Reed, the Office of Personnel Management provided Direct Hire Authority for over 100 patient care (medical and support) positions. The Army made 125 job offers at the recent Walter Reed "Caring for America's Heroes" Job Fair.

FEEDBACK FROM SERVICE MEMBERS AND FAMILIES

One of the most important things we can do to ensure that we are taking care of our wounded soldiers is to get feedback from them personally. To ensure we meet and exceed future expectations of Service members and their families, the Department of the Army set up a toll-free hotline to receive beneficiary input. TRICARE Management Activity and the Veterans Administration are integral components of the call center ensuring full-spectrum resolution of medical issues. In addition, we are conducting surveys of wounded warriors and their families, so we may assess what is going well and identify areas that need improvement. The first military health system survey is being fielded this month with initial results expected in June.

PROCESS OF DISABILITY DETERMINATIONS

With respect to disability determination, let me just say that Service members deserve fair, consistent and timely determinations. Complex procedures must be streamlined. The system must not be adversarial. We have several efforts underway – a fast track look at possible system changes for those injured or wounded in combat and a systemic look at the disability evaluation process for all. We have convened senior leaders of the Military Departments and the Office of the Secretary of Defense to begin the process of designing a system optimized for our wounded and severely wounded service members, speeding disability determinations and providing support for their transition to civilian life. Further, this afternoon, together with our partners in Veterans Affairs, we will begin a comprehensive re-design of our processes affecting the other 15 to 20,000 people annually who move through our disability evaluation and separation systems.

The Military Departments' Personnel Chiefs and Surgeons General recommended we charge the Disability Advisory Council with updating the set of directives and instructions that promulgate disability policies. We have done so. We have also tasked this group with strengthening oversight processes and making recommendations on program effectiveness measures. The Department has established working groups, under the Disability Advisory Council, consisting of senior human resource and medical subject matter experts from the Military Departments and the Office of the Secretary of Defense to address issues such as training, oversight and consistency of application. Additionally, we have invited representatives from the Department of Veterans Affairs (DVA) to sit on the Council to assist the process as we strive for a seamless transition for our servicemembers from the DoD Disability system to the VA system. We anticipate revised DoD instructions will be completed in May 2007.

In addition to our DoD-level initiatives, the Military Departments are also continually reviewing their processes to make them more effective. For example, Army leadership recently established a Physical Disability Evaluation System (DES) Transformation Initiative which integrates multiple major commands and the Department of Veterans Affairs. This combined effort targets improving process efficiency and timeliness in areas such as: Military Evaluation Board and Physical Evaluation Board processes, automation of disability data, counseling and training, and transition assistance. Additionally, in November 2006, the Army directed an internal Inspector General review of its DES process. I understand that the report is due out this fall.

PROCESS OF PROGRAM AND CARE COORDINATION

The quality of medical care we deliver to our Service members is exceptional, as evaluated by numerous independent reviews. Yet, we need to better attend to the coordination of services for members in long-term outpatient, residential rehabilitation and we must streamline the transition from DoD to VA. We are evaluating with VA a single case manager model. Additionally, we will assess and work towards the proper ratio of case-managers-to-wounded Service members. We will also assess the administrative and information systems in place to properly manage workload in support of the Service members and families.

We are committed to identifying and correcting the shortcomings that involve the joint responsibilities of the Departments of Defense and Veterans Affairs (VA). We have already begun working with our colleagues on corrective action. We are focused on facilitating a coordinated transition, enabling Service members, veterans, and their families to navigate a complex benefits systems with relative ease – a seamless transition. We have joined with the VA in a coordinated organizational structure. The VA/DoD Joint Executive Council, co-chaired by DVA Deputy Secretary Gordon Mansfield and Under Secretary of Defense David Chu provides guidance and policy for collaborative efforts. There are two subordinate counsels – one focused on health care issues, another on veterans' benefits. I will describe several of our ongoing efforts.

- One program under the purview of the Benefits Executive Council (BEC) resulted in agreements between DoD and VA officials at 130 different locations for both agencies to use the same, single separation physical. This program, called Benefits Delivery at Discharge (BDD), also brings claims specialists from the Veterans Benefits

Administration (VBA) into DoD facilities to assist Service members in filing disability claims as early as six months before they leave uniform.

- The Army Liaison/VA PolyTrauma Rehabilitation Center Collaboration program, a "Boots on the Ground" program, stood up in March 2005. The intent of this collaborative effort is to ensure that severely injured Service members who are transferred directly from an Medical Treatment Facility to one of the four VA PolyTrauma Centers (in Richmond, Tampa, Minneapolis, and Palo Alto), are met by a familiar face in a uniform.

DOD has a long-standing relationship with the VA, in which VA provides rehabilitative services for patients with traumatic brain injuries, amputations, and other serious injuries as soon after the incident as clinically possible. A staff officer or non-commissioned officer assigned to the Army Office of the Surgeon General is detailed to each of the four PolyTrauma Centers. The role of the Army liaison is primarily to provide support to the family on a broad array of issues, such as travel, housing, and military pay. The liaisons have also played a critical role in the rehabilitation process by promoting resiliency in Service members. The presence of a uniformed liaison reassures these Service members and their families that we appreciate their service and are committed to ensuring their needs are met by our sister agency.

The Joint Seamless Transition Program, established by VA, in coordination with the Military Services, assists severely injured Service members while they are still on active duty so that they can more timely resolve benefits. There are 12 VA social workers and counselors assigned at ten of DoDs Medical Treatment Facilities, including Walter Reed Army Medical Center and the National Naval Medical Center in Bethesda.

They ensure the seamless transition of health care between DoD and VA by coordinating in advance the inpatient care and outpatient appointments at the VA medical center to which the patient will be moved. They follow-up with patients to verify success of the transfer plan, and to ensure continuity of therapy and medications. Case managers also refer patients to Veterans benefits counselors and vocational rehabilitation counselors. Veterans Benefit Administration counselors visit all severely injured service members and inform them of the full range of VA services, including readjustment programs, and educational and housing benefits. As of February 28, 2007, VA social worker liaisons had processed 7,082 new patient transfers to Veterans Health Administration (VHA) at the participating military hospitals.

• The Recovery and Employment Assistance Lifelines (REALifelines) initiative is a joint project of the U.S. Department of Labor, the Bethesda Naval Medical Center and the Walter Reed Army Medical Center. It creates a seamless, personalized assistance network to ensure that seriously wounded and injured service members who cannot return to active duty are trained for rewarding new careers in the private sector. Realifelines works closely with the VA's Vocational Rehabilitation program to ensure Service members have the skills, training, and education required to pursue their desired career field. The Department of Homeland Security's Transportation Security Administration has a transportation specialist assigned to the Center to facilitate travel of severely injured members and their families through our nation's airports. The Center's TSA liaison coordinates with local airport TSA officials to ensure that each member is assisted throughout the airport and given a facilitated (or private) security screening that takes into account the member's individual injuries.

INFORMATION SHARING

The programs and benefits earned by Service members could not be delivered without complete cooperation between the DOD and the VA in the area of information sharing. Indeed, information sharing is critical to an effective and transparent transition process, and that is why so much attention is paid to information management and information technology in the JEC's Joint Strategic Plan.

- Electronic Health Records. The Federal Health Information Exchange (FHIE) is an electronic transfer of protected health information from DOD to VA at the time of the Service member's separation. The data contained in this transfer include: pharmacy and allergy data; laboratory and radiology results; consult reports; discharge summaries; admission, disposition and transfer information; and patient demographic information. Health care providers within VHA, and benefits counselors within VBA, access this information via the Computerized Patient Record System and Compensation and Pension Records Interchange, respectively. As of the end of March 2007, DOD has transmitted health data on more than 3.8 million patients.

Building on the success of FHIE, DOD now sends electronic pre- and post-deployment health assessment and post-deployment health reassessment information to the VA. We began this monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository in September 2005, and the post-deployment health reassessment in December 2005. As of February 2007, VA had access to digital data comprising more than 1.6 million pre- and post-deployment health assessments and post-deployment health re-assessment forms on more than 681,000 separated Service members and demobilized National Guard and Reserve members who

had been deployed. In December 2006, we added weekly data pulls of post-deployment health reassessments for individuals referred to the VA for care or evaluation.

To support our most severely wounded and injured Service members transferring to VA PolyTrauma Centers for care in March 2007, DOD started sending radiology images from Walter Reed Army Medical Center (WRAMC) and National Naval Medical Center (NNMC), Bethesda to the Tampa VA PolyTrauma Center. DOD plans to expand the capability to Brooke Army Medical Center (BAMC) and the other three VA PolyTrauma Centers in Minneapolis, Richmond, and Palo Alto. In addition, Walter Reed AMC also began scanning paper medical records and sending them electronically for the patients transferring to the Tampa VA PolyTrauma Center. DOD plans to expand this capability to encompass scanning records from NNMC and BAMC for patients transferring to any of the four VA PolyTrauma Centers.

Building from the FHIE, which is a one-way flow of information, DOD and VA have developed and begun deployment of the Bi-Directional Health Information Exchange (BHIE). This electronic exchange enables near real-time sharing of allergy, outpatient prescription, inpatient and outpatient laboratory and radiology results, and demographic data between DOD and VA for patients treated by both departments. BHIE is operational at all VA medical centers and at 14 DOD medical centers, 19 hospitals, and over 170 outlying clinics.

With an eye toward the future and to accelerate progress in sharing appropriate health information, the VA/DOD Health Information Technology Sharing Working Group established in FY 2006 an interface between BHIE and the DOD Clinical Health Data Repository. In the third quarter of this fiscal year, all DOD sites and all VA sites

will be able to view data from the other Department for shared patients. We are also focusing on increasing the amount of inpatient data exchanged. Most recently, BHIE began to exchange inpatient and emergency department discharge summaries. Other inpatient documentation, such as operative reports and inpatient consultations, are planned for the future.

DOD is aware of the concerns regarding the time it has taken to establish the desired level of interoperability. With the full deployment of DOD's electronic health record (EHR) – AHLTA – across the Military Health System accomplished, we are poised to continue building on our significant achievements in sharing critical health information across agency lines.

We are currently testing our ability to share inpatient information. In September 2006, DOD and VA began exchanging clinical information between clinical data repositories. Health information sharing of this magnitude has never been done before.

- The Clinical Data Repository/Health Data Repository (CHDR) is a DOD-VA interface. It exchanges standardized and computable pharmacy and medication allergy data. The pharmacy and allergy information supports drug-drug and drug-allergy order checking for shared patients, using data from both DOD and VA. DoD and VA have implemented this capability at eight sites. And, by July, DOD will allow all of its remaining locations to begin using this interface.

The ultimate desired end-state will be a completely electronic health care record that is accessible and useable to the provider regardless of which health care system they are operating within.

OTHER INFORMATION SHARING PROGRAMS

I want to discuss two additional information sharing programs that provide VA with essential data in order to expedite the benefits delivery process. First, DOD is providing contact information for Service members when they separate. In September 2003, DOD began routinely providing VA with rosters on recently separated OEF and OIF veterans – Active Duty and Reserve Components. VA uses these lists to distribute to veterans information on VA benefits related to service in a combat theater. Over 580,000 letters have been mailed.

Second, DOD is transmitting to VA's Office of Seamless Transition a monthly list of key demographic and contact information on Service members who have been referred to a Physical Evaluation Board. This list enables VA case managers to make contact with Service members at the earliest time possible, while they are still in uniform. DOD began electronically transmitting pertinent data to the VA in October 2005 and continues to provide monthly updates. We have provided information for more than 16,000 Service members while they were still on active duty, allowing the VA to better project future workload and resource needs.

DEPLOYMENT AND POST DEPLOYMENT HEALTH

For several years now, DOD has been performing health assessments on Service members prior to and just after deployment. These assessments serve as a screen to identify any potential health concerns that might warrant further medical evaluation. This includes screening the mental well-being of all Soldiers, Sailors, Airmen and Marines in both the Active and Reserve Components.

Every year, members are screened for mental health problems when they complete a preventative health assessment. Now, they are again screened before they

deploy. In addition, before returning home from deployment, members complete a post deployment health assessment, which contains questions aimed at identifying physical or mental health concerns; environmental exposure concerns; psychosocial concerns, such as acute post traumatic stress disorder, depression, anger, or inter-personal conflict; and potentially unexplained symptoms.

The Services are now implementing an additional health reassessment that is conducted 3-6 months after returning home – the Post Deployment Health Re-Assessment. Our experience has taught us that problems are not always apparent at the time Service members are immediately returning home, but they may surface a few weeks or months later. We want to assist in early identification of these concerns and facilitate ready access to care at the level most appropriate to the individual Service member.

Because of challenges faced by our forces, some Service members may develop chronic mental health symptoms. Mental health experts from the DOD and VA developed joint clinical practice guidelines for acute and post traumatic stress disorder, major depressive disorder, substance use disorders, medically unexplained symptoms, pain, and general post deployment health concerns. DOD uses all available resources, including local military or TRICARE providers (a benefit extended for up to 180 days post deactivation for Reservists); to provide treatment for affected Service members. VA is a partner in this process by providing health care and counseling services to Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans who are no longer on active duty.

To supplement mental-health screening and education resources, we added the Mental Health Self-Assessment Program, or MHSAP, in 2006. This program provides military families, including National Guard and Reserve families, Web-based, phone-based and in-person screening for common mental-health conditions and customized referrals to appropriate local treatment resources. The program includes screening tools for parents to assess depression and risk for self-injurious behavior in their children. The MHSAP also includes a suicide-prevention program that is available in DoD schools. Spanish versions of these screening tools are available.

The Department is working on a number of measures to evaluate and treat Service members affected or possibly affected with traumatic brain injury (TBI). For example, in August 2006, we developed a clinical-practice guideline for management of mild TBI in theater for the Services. We sent detailed guidance to Army and Marine Corps line medical personnel in the field to advise them on ways to deal with TBI. The clinical-practice guideline included a standard Military Acute Concussion Evaluation (MACE) form to assess and document TBI for the medical record. We are also conducting research in the inpatient medical area. Furthermore, to enhance the Periodic Health Assessment, Post-Deployment Health Assessment and Post-Deployment Health Reassessment, we directed inclusion of questions on TBI to capture data that will contribute to a better understanding of TBI identification and treatment. In addition, these questions will help identify Service members possibly exposed to events that caused TBI that were not documented at the time of exposure. As of April 2007, the VA is screening all OIF/OEF veterans receiving medical care within the VA for possible TBI. This screening further provides a systematic approach to identify and treat individuals

that may have experienced a brain injury. Those veterans who screen positive for a possible symptomatic TBI are then referred for specialized follow up care within the VA.

We published a new DOD Instruction, "Deployment Health," in 2006. Among its many measures to enhance force health protection is a requirement for the Services to track and record daily locations of DOD personnel as they move about in-theater and report data weekly to the Defense Manpower Data Center. We can use the data collected to study long-term health effects of deployments and mitigate health effects in future conflicts.

HEALTH CARE FOR THE RESERVE COMPONENT

At the direction of Congress, we have implemented new health benefits that extend TRICARE coverage to members of the Guard and Reserve. We implemented the TRICARE Reserve Select (TRS) health plan for Reserve Component personnel and their families as mandated in the NDAA for FY 2005, and then amended in the NDAA for FY 2006. We are now working on the new program mandated by the NDAA for FY 2007. Today, more than 34,000 reservists and their families are paying the premiums and getting TRS coverage. We have made permanent their early access to TRICARE upon receipt of call-up orders and their continued access to TRICARE for six months following active duty service for both individuals and their families.

The Department is committed to providing the assistance and support required to meet the challenges that confront our severely injured and wounded Service members, and their families.

The Department of Defense cares deeply about the well-being of its people. It has been painful to learn, as we have recently, that some of those recuperating from injury have not received the kind of care they deserve.

We have taken this sobering information as a call to action. Today we are making dramatic improvements in our system, discarding outdated assumptions, removing bureaucratic roadblocks, improving information sharing, and re-focusing our attention on the one thing that matters most: The health and well-being of our courageous Service men and women. We have done much, but there is more to do. We look forward to the results of every review effort in order to improve and continuously improve support to our warriors and their families.

Mr. Chairman, this concludes my statement. I look forward to working with the committee in this new Congress to uphold our traditional outstanding support of American heroes – our Nation's Servicemen and women, veterans, and their families.

Mr. TIERNEY. Thank you, Mr. Secretary. I do note, however, that the last hearing we had on March 5th, where we asked the witnesses there from a similar panel how much time we ought to give for review on where they have been and where they have gone, 45 days was the date given, so I know I have read General Pollack's statement. I think she is going to be a little more distinct in what she says has been done to date. But I am hoping we have some things accomplished and not just waiting for other people to file reports on that.

Mr. DOMINGUEZ. Yes, sir, we are moving out and we have accomplished many things.

Mr. TIERNEY. Thank you.

General Pollack, please.

STATEMENT OF GENERAL GALE S. POLLACK

General POLLACK. Mr. Chairman, distinguished members of the subcommittee, I am delighted to have this opportunity to discuss with you the actions the Army is taking to improve the way that we care for and support our warriors in transition and their families. I also want to thank the former Secretaries of the Army, Secretary Marsh and Secretary West, for their leadership on the Independent Review Group. The work of the IRG and the other commissions viewing the Department of Defense physical disability evaluation system is very important as we continue to re-engineer the Army's medical and physical evaluation system.

Our Army medical action plan is fast-paced and flexible so we can quickly assimilate the recommendations from these groups into our ongoing efforts.

On March 5th, Secretary Garon, General Schoomaker, and General Cody testified before this subcommittee at Walter Reed Medical Center and vowed that the Army would work aggressively to identify and fix the problems at Walter Reed. They told the subcommittee "we would not wait for reports or recommendations, but that we would fix things as we go." This is exactly what we have been doing.

On April 3rd, the Army's medical holdover Tiger Team included an exhaustive study of the Army's 11 key medical treatment facilities. This team included experts in finance, personnel management, medical care, and representatives from the U.S. Army Installation Management Command. The Tiger Team not only inspected facilities to identify problems, but also sought best practices in the care and support of those warriors in transition. These practices can be applied at Walter Reed and implemented across the Army Medical Command.

The team found that outstanding and innovative work is being done by many great Americans, military and civilian, given available resources. There is ample evidence that warriors are receiving high quality health care and are generally satisfied with our efforts and their clinical and administrative outcomes.

The team identified several best practices, including the establishment of a deployment health section, dedicated medical evaluation board physicians, and scheduling followup appointments with the Department of Veterans Affairs prior to their separation.

On March 19th the Army established a 1–800 hotline for warriors and their families who want to raise their concerns to the Army leadership. The hotline allows soldiers and their families to gather information about medical care, as well as to suggest ways to improve our medical support systems.

The hotline rings in the Army Operations Center and all calls are logged, tasked for followup within 24 hours, and briefed weekly to Army leadership.

As of April 9th, the Army had received 848 calls detailing 468 distinct issues. Of this total, only 245 were medical issues, and 162 were tasked to the Army Medical Command for research and resolution.

Last week, in answer to one of the Members' questions, we trained 23 soldiers to work as warrior ombudsmen across the Army Medical Command. The ombudsman is considered another warrior resource and is not a means of circumventing the soldiers' chain of command. The intent of this program is to help cut through the red tape by linking soldiers and family members with the correct sources of information in order to answer questions or resolve issues emanating from a lack of understanding or simply confusion.

This plan ensures that soldiers have additional advocates, while we correct the administrative process that will require policy or legislative change.

We have much work to accomplish. We are aggressively improving the existing physical disability evaluation system to minimize the difficulties soldiers have faced. The system was developed half a century ago and has become overly bureaucratic and too often adversarial. You have heard that often today.

The Army is developing initiatives to overhaul or replace the current process. Rather than settle for yet another attempt to re-engineer current processes, our goal is to eliminate the bureaucratic morass altogether and develop a streamlined process to best serve our soldiers.

As we move forward, there will be areas of policy, process, and administration requiring full collaboration and coordination between both DOD and VA. We have worked together in the past, and it is imperative that we expand that partnership to clarify the issues, fix the problems, and improve the process for our servicemen and women.

We are under no allusions that the work ahead will be easy or cheap or quick. We have a lot to do to get this right. Fixing the myriad issues we have recently uncovered will take energy, patience, determination, and, above all, political will. Soldiers are the centerpiece of your Army and the focus of our efforts. Soldiers should not return from the battlefield to fight an antiquated bureaucracy. Wounded, injured, and ill service members and their families expect and deserve quality treatment and support as they return to their units or their communities.

We know that the President, Secretary Gates, Secretary Nicholson, Secretary Garon, the Congress, and the American public are committed to this effort, as it is the cornerstone of everything we are doing. With your help and the help of all the agencies involved, we are confident that we can match the superb medical care soldiers receive at the point of injury or illness, whether on the battle-

field or during training, with simple, compassionate, and expeditious service that ensures every soldier knows the Army and the Nation are, indeed, grateful.

Thank you, again, for your invitation to testify. I look forward to your questions.

[The prepared statement of General Pollack follows:]

RECORD VERSION

STATEMENT BY

MAJOR GENERAL GALE S. POLLOCK
ACTING SURGEON GENERAL, UNITED STATES ARMY
&
COMMANDING GENERAL, US ARMY MEDICAL COMMAND

AND

MAJOR GENERAL ERIC B. SCHOOMAKER
COMMANDING GENERAL
NORTH ATLANTIC REGIONAL MEDICAL COMMAND
&
WALTER REED ARMY MEDICAL CENTER

BEFORE THE

HOUSE OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
SUBCOMMITTEE ON NATIONAL SECURITY AND FOREIGN AFFAIRS

FIRST SESSION, 110TH CONGRESS

ON THE CARE AND CONDITIONS FOR WOUNDED SOLDIERS

APRIL 17, 2007

NOT FOR PUBLICATION
UNTIL RELEASED BY THE HOUSE OVERSIGHT AND GOVERNMENT
REFORM COMMITTEE

Chairman Tierney, Mr. Shays and distinguished members of the Committee, thank you for inviting us here today to speak about caring for our Soldiers and their families and the improvements we are making in response to the findings of substandard living conditions and bureaucratic administrative processes at Walter Reed Army Medical Center.

There is no greater duty we have as a nation than to ensure those Soldiers who volunteer to defend our freedom are treated with not only the best medical and transitional care we can provide, but with the dignity and compassion they deserve. Whether wounded in war, injured in training, or taken ill, our Soldiers deserve the very best that our Nation can offer to honor their service and sacrifice.

In some areas, regrettably, we have not lived up to that obligation. The superhuman work done by medics, fellow Soldiers, and military nurses and doctors--from all Services--to ensure that our Soldiers survive combat and receive quality care has been undermined by an outdated and bureaucratic system that leaves recovering Soldiers and their families frustrated and often angry.

To be sure, the Army cannot solve the system's many problems alone. However, based on the progress we have made to date and the work we continue doing to identify specific remedies, we know that together, the Army, the Department of Defense (DoD), the Department of Veterans' Affairs (VA), many non-Governmental philanthropic groups and the Congress can provide the

compassionate, seamless, and robust healthcare system that our Soldiers and their families have earned and deserve.

We'd like to begin by providing an update on your Army's progress in addressing issues at Walter Reed Army Medical Center. On March 5th, the Acting Secretary of the Army, the Chief of Staff, and the Vice Chief of Staff testified before this subcommittee at Walter Reed Army Medical Center and vowed that the Army would work aggressively to identify and fix the problems at Walter Reed. They told the subcommittee we would not wait for reports or recommendations, but that we "would fix things as we go." Today we are pleased to report that we have made a great deal of progress in the areas of leadership, infrastructure, and process-related issues, as we work toward a Soldier and family-centric health care system that is supported by the triad of: a caring and energetic chain of command; a primary care physician; and a Registered Nurse case manager. All soldiers undergoing evaluation, treatment, rehabilitation, transition to return to duty, return to active and productive civilian life or medical retirement and continued care and rehabilitation are now termed "Warriors In Transition".

With regard to leadership issues, we believe we have the right people and the right mechanisms in place to make sure that all Soldiers who are in a transitional status—our Warriors in Transition--are managed with care and compassion, and that they and their families are receiving the care they so justly deserve. Every Warrior In Transition has an NCO who is fully accountable for his or her welfare. And these NCOs are well-led and supported by an engaged and

well-trained Chain of Command of more senior NCOs and officers. Among other improvements for our families, Walter Reed leaders now greet family members at the airport and escort them to the hospital, letting them know in word and deed that they and their Soldiers have a working support system.

Your Army is committed to continuous infrastructure maintenance and improvements at Walter Reed. As you know, we no longer house Soldiers in Building 18 and are evaluating the long-term use of that facility. There is a facility assessment team on-site, contracted by the Baltimore District, US Army Corps of Engineers, conducting a thorough evaluation of the installation's infrastructure. Meanwhile, immediate information technology upgrades to provide telephone, internet, and cable television for Soldiers in all on-post lodging facilities have been completed.

The Warrior Transition Brigade, to which our Warriors In Transition are assigned, will formally activate on April 25th 2007 and will be fully operational on June 7th. We are adding over 130 military positions to the leadership team that provides daily care and leadership for our medical holdover soldiers, and creating new leadership posts for company commanders, first sergeants, and squad leaders (SL). This substantially reduces the noncommissioned leader-to-led ratio at the platoon level (from roughly 1:55 to one closer to that which all Army units operate at 1:12). Just like Soldiers in every unit in the Army, these Soldiers now have a full chain of command, starting at the squad leader level, to look after their health and welfare.

A Clothing Issue Point recently began operations to replace items such as undergarments and uniforms, as appropriate, for Soldiers evacuated from theater to Walter Reed.

We have enhanced access to the hospital dining facility and established special meal cards to prevent Soldiers from losing their basic allowance for subsistence.

As many of you know, the Mologne House on the Walter Reed campus is home to many of our medical holdovers. For all intents and purposes, it serves as "step-down rehabilitation unit" for Warriors In Transition and their families and friends. There is now an emergency medical technician on-site at Mologne House 24 hours a day, 7 days a week, a change that has been well received by Soldiers and family members. We are incorporating this plan into the soldier and family-center care program which focuses on the PCM-CM-SL triad described earlier.

We have also improved information dissemination and feedback mechanisms. A weekly Newcomer's Orientation informs Soldiers and families of all programs available to them at Walter Reed. Recently, the WRAMC command conducted two Town Hall meetings to make sure that we are aware of the issues most important to our Warriors and their families, and have incorporated that feedback into our plans and processes. The Town Hall meetings are a success and will continue.

Soldiers and their families were given a Family Member Hero Handbook and 1-800 Hotline cards. The Hotline allows Soldiers and their families to gather

information about medical care as well as suggest ways to improve our medical support systems. These cards are being distributed throughout the force, and so far the result has been very encouraging. By April 9th, we had received 848 calls detailing 468 distinct issues. Of these 245 were medical issues and 162 were tasked to US Army Medical Command for research and resolution.

On the issue of process and the care of our families, the Soldier and Family Assistance Center (SFAC) opened its doors on March 23rd, 2007. The SFAC brings together assistance coordinators, personnel and finance experts, and representatives from key support and advocacy groups such as the U.S. Army Wounded Warrior Program, the Red Cross, Army Community Services, Army Emergency Relief, and VA. Co-locating these organizations provides one-stop service to Soldiers.

Also, we have begun a more efficient and thorough system for transferring our Warriors In Transition from inpatient to outpatient status. At Walter Reed, a complete review of our discharge management process resulted in a revision of standard operating procedures. We developed a discharge escort system whereby hospital staff, including the brigade leadership, comes to the Soldier to conduct discharge business, escort the Soldier to the brigade, and assist with luggage and transition into the unit. We instituted training to re-emphasize the importance of *hospitality* for our Soldiers and their families.

The Physical Evaluation Board (PEB) process, which determines if a Soldier is fit to continue performing his or her duties, is one of the most daunting a Warrior In Transition can face. We have significantly increased the number of

Physical Evaluation Board Liaison Officers (PEBLO) to help Soldiers navigate this process. (The ratio of PEBLO to Soldier has improved from 1:45 to 1:30). Standardization of the case management process, coupled with increased case managers (CM) and PEBLOs, has significantly improved the level of service we provide to the Soldier. And importantly, we will soon see an improved ratio of case managers to patients, from 1:50 to one close to that of the SL to Warrior In Transition ratio. In fact, these CMs will be teamed with the SL at the company level to which the WIT is assigned. This should permit better coordination of treatment and evaluation.

The Acting Secretary of the Army and the Chief of Staff also vowed to address similar issues around the country and in the medical system at large. He and the Army leadership assigned a senior line General Officer—a "bureaucracy buster"—to the WRAMC, the North Atlantic Regional Medical Command (NARMC) and the US Army Medical Command (USAMEDCOM) to assist the CG, WRAMC/NARMC and the Army Surgeon General in leading the changes across the Army Medical Department. To provide data for his and his team's work, on April 3rd, the Army's Medical Holdover Tiger Team concluded an exhaustive study of the Army's 11 key Medical Treatment Facilities at Forts Bragg, Gordon, Stewart, Campbell, Knox, Sam Houston, Hood, Bliss, Lewis, Drum, and Schofield Barracks. This team included experts in finance, personnel management, medical care, and representatives from US Army Installation Management Command. The Tiger Team not only inspected facilities to identify problems but also sought out best practices. These practices are being

incorporated into the Army Medical Action Plan, are being applied and tested at WRAMC and, if successful, will be implemented across the USAMEDCOM.

We are aggressively making improvements to the existing Physical Disability Evaluation System (PDES) to minimize the difficulties that Soldiers are facing. This system was developed half a century ago and has become overly bureaucratic and, too often, adversarial. The Army has undertaken corrective action and we are developing initiatives to overhaul or replace the current process. Indeed, rather than settle for yet another attempt to reengineer current processes, our goal is to eliminate the bureaucratic morass altogether, and develop a more streamlined process to best serve our Soldiers. And to better serve those now returning from Iraq and Afghanistan, Deputy Defense Secretary England recently called for a new policy that moves wounded troops to the front of the line in the disability rating process while system-wide fixes are put in place.

As we move forward to transform the PDES, there will be areas of policy, process, and administration requiring full collaboration and coordination involving both DoD and VA. We have worked together in the past, and it is imperative that we continue that partnership in order to identify the issues, fix the problems, and improve the process for our service men and women.

Specific areas for improvement include: Soldier processing within Medical Evaluation Boards (MEB) and Physical Evaluation Boards (PEB); training of physicians, adjudicators, administrators, and legal advisors; establishing standard counseling packages and procedures; and ensuring that the automation systems supporting the PDES are interconnected.

Currently, the Army is determining the manpower and funding requirements for each initiative and it is our intention to implement them within the next 60 days. For example, we are reducing the number of forms Soldiers have to complete, and transmitting documents electronically rather than through the mail.

Our Warriors In Transition have been frustrated by inconsistent processing of their orders. We have issued a military personnel message that clarifies how orders for Soldiers should be processed.

We continue to address concerns that PEBLOs are ill-prepared to carry out their duties. We have conducted training for our PEBLOs via Video Teleconference and in May we will hold a PEBLO Training Conference on solving problems for Soldiers in Medical Hold and Medical Holdover status.

The transition of our Warrior medical care from DOD to VA should be seamless; right now, it is not, leaving soldiers and their families confused and frustrated.

The process can't be seamless if the edges don't touch. In this case, the "edges" between DoD and VA are the administrative hand-off in medical management and the disability determination. We continue to work with VA to ensure timely access to health records for VA providers. Bi-directional health information exchange is now operational at all DVA healthcare facilities and at over 200 DoD facilities. The VA/DoD Joint Executive Council and Health Executive Council continue to pursue a variety of other efforts to achieve seamlessness on the health information technology front. We must work

together to minimize the number of physical examinations and repeat diagnostic testing that our warriors in transition must undergo, and as much as possible, collocate our facilities and share resources. Again, these long-term solutions will be the result of a collaborative effort between the services, DoD, VA, other State and federal agencies, and the Congress.

These are just a few of the actions that we have taken to address these serious issues. We have yet to receive and/or fully digest the reports of other groups that are looking into these same problems, but we look forward to reviewing their recommendations.

We are also reviewing the findings and recommendations of the independent review group, co-led by former Army Secretaries Jack Marsh and Togo West. The Army will carefully study its findings and recommendations and will keep you informed as we move through the appropriate corrective actions.

Finally, the Nicholson Task Force and the Dole-Shalala Commission findings are forthcoming and will be valuable as we work together to define further and address the challenges we face. Our Army Medical Action Plan is fast-paced and flexible and we will quickly assimilate the recommendations from these groups into our on-going improvements.

We are under no illusions that the work ahead will be easy or quick...or cheap; we have a lot to do to get this right. Mending the seams and fixing the myriad issues we have recently uncovered will take energy, patience, determination and above all, political will.

Soldiers are the centerpiece of the Army and the focus of our efforts. Soldiers should not return from the battlefield to fight an antiquated bureaucracy. Wounded, injured, and ill service members and their families expect and deserve quality treatment and support as they return to their units or their communities. We know that the President, Secretary Gates, Secretary Nicholson, Secretary Geren, the Congress and the American public are committed to this effort as the cornerstone of everything we are doing. We simply ask for your continued support as we strive to provide the best care for those who give so much to protect us all.

With your help, and the help of all the agencies involved, we are confident that we can match the superb medical care Soldiers receive at the point of injury or illness, whether on the battlefield or during training, with simple, compassionate and expeditious service that ensures every Soldier knows the Army and the Nation are indeed grateful.

Thank you again for inviting us to testify. We look forward to your questions.

Mr. TIERNEY. Thank you, General.
General Schoomaker, do you have a statement?

STATEMENT OF MAJOR GENERAL ERIC SCHOOMAKER

General SCHOOMAKER. Mr. Chairman, Congressman Shays, distinguished members of the subcommittee, I am Major General Eric Schoomaker. I command the U.S. Army North Atlantic Regional Medical Command and the Walter Reed Army Medical Center.

I join Major General Pollack and the Department today in thanking the subcommittee for the opportunity to discuss the many improvements in living conditions for our patients at Walter Reed campus, our efforts to improve command and control and accountability for soldier welfare, and what we have done to build a warrior-centered and a family centered program at Walter Reed and throughout my regional medical command and beyond, to the medical command of the whole Army.

First, I want to reassure the committee and the Congress the Army, the U.S. military, the American people, that the quality of medical and surgical nursing, psychiatric, rehabilitative, and other care that is delivered at Walter Reed Army Medical Center, our sister medical treatment facilities within my region that include Fort Bragg, NC; and Fort Knox, KY; and Fort Drum, NY, and others. The U.S. Army Medical Command under General Pollack has never been in question and remains the highest quality. Frankly, it was heartening to hear Congressman Shays say that we provide an unparalleled level of care within our hospitals, and that survival on the battlefield has reached unprecedented levels in the history of American warfare.

Shortly after national attention was drawn to Walter Reed and our care of wounded warriors, an unannounced inspection of the hospital was conducted by the Joint Commission. This is the Nation's leader in accrediting hospitals and health care systems. We were reassured by their finding of high quality health care overall, while directing us to areas of improvement, especially in the transition from inpatient to outpatient care. We fully addressed these areas with a comprehensive program for outpatient warrior care management, some steps of which I will outline in a few minutes.

The Army and the DOD leadership pledged that we would fix the problems as they were identified. I think that has been a question from the subcommittee all morning. Armed with insights derived from media accounts, your subcommittee's earlier hearings that were held at Walter Reed on March 5th, town hall meetings I conducted personally immediately after taking command over a month ago, and the excellent recommendations provided by the Independent Review Group under former Secretaries of the Army, Marsh and West, and many others, we have done exactly that. We are eagerly applying best practices from our colleagues in the Army Medical Command and Navy and Air Force medicine, and we are actively seeking new ideas for improving care, for administrative oversight, and services for patients and families during this important transitional period in their lives. We call these soldiers warriors in transition. They are returning to duty after an injury or an illness. They are returning to full and productive civilian life after a recovery. Or they are retiring with a medical disability for

continued care and rehabilitation, and hopefully employment within their communities.

We are clear to separate those issues which are unique to the Walter Reed campus for which I am accountable, those that are Army- and DOD-wide problems, and those for which solutions lie in the interagency area.

All patients, I can reassure you, were moved out of Building 18 almost immediately. They have been moved into newer barracks on the installation. Many of you have come and seen those new barracks. The building, Building 18, will never again be used to house patients or families. The new barracks have been further upgraded with state-of-the-art computers and communications. The Army has been extremely forthcoming with that and very aggressive in their support.

A comprehensive survey of all critical housing and life support infrastructure on Walter Reed installation is being conducted, and repairs are being performed on a priority basis as they are identified by this team.

The Acting Secretary of the Army and the new Chief of Staff of the Army have made it very clear that we should restore Walter Reed to a standard which makes all of us proud to work and live on that installation until we build and occupy the new Walter Reed National Military Medical Center with our Navy colleagues in Bethesda, MD, under the provisions of the BRAC plan.

Among the most important improvements is the infusion of new leadership officers and non-commissioned officers, beginning with my new Deputy Commander, Brigadier General Mike Tucker, a combat veteran and a line commander—he is our bureaucracy buster, as he has been called—and our new Warrior in Transition Brigade Commander, Colonel Terry McKendrick, also a combat veteran, and his Command Sergeant Major, Jeff Heartless, who, as a combat veteran, has also been a patient in our hospital and is very savvy about the problems that soldiers and warriors confront.

With my new Command Sergeant Major Althea Dixon, we have given every warrior in transition a new chain of command with a smaller span of control for added accountability for their welfare. Additionally, we have added better trained nurse case managers to ensure fluid administrative processes, and primary care physicians for assurance that medical care is coordinated and is of the highest quality.

I am here today to answer any additional questions you may have for me or my command about the improvements in care, our living conditions, and the administration of this critical transitional period in the lives of our soldiers and their families. Thank you again for the opportunity to serve in this fashion.

Mr. TIERNEY. Thank you all for your statements.

Mr. Braley, you have 5 minutes.

Mr. BRALEY. Thank you, Mr. Chairman. Thank you to the panel.

Mr. Dominguez, let me start with you. You talked about the supplemental request for $50 million for the medical support fund. Were you aware that in the supplemental passed by the House there was $1.7 billion above the President's budget request for DOD medical assistance, and also $1.7 billion of additional funding for the VA?

Mr. DOMINGUEZ. No, sir.

Mr. BRALEY. I would suggest that you talk to people within the Department to see what can be done within the parameters of those additional appropriations to find room for the $50 million, which I think would be a completely appropriate use of that funding that was added to the supplemental.

Mr. DOMINGUEZ. Congressman, Secretary Gates is committed to fixing the problem and doing what is right. That is his standard he has set. As we were talking about before the hearing with the chairman, the resources are available. It is about making tough choices. I appreciate that the Congress has made those choices in enacting the supplementals that you have done. We will make the tough choices, too, to get the job done.

Mr. BRALEY. One of the issues that seems to come up over and over again is the whole inconsistency in the disability evaluation process between the DOD and VA disability system, and one of the concerns that is identified in the written statements has to do with that process becoming adversarial, which is something you identified and General Pollack, you also mentioned.

The reason why those systems become adversarial is because patients feel like they aren't being taken care of and their concerns aren't being heard. I did town hall meetings with veterans groups throughout my District the last 2 weeks when we were back in recess, and this is the No. 1 concern I heard from veterans advocacy groups is the backlog of disability claims, and that is why at the March 5th hearing I specifically asked the final panel how many patient advocates were there to assist people in the disability process at Walter Reed.

It was very disturbing to me that there was a misunderstanding of the role that case managers and patient advocates play, and one of the concerns I have about an ombudsman program is typically an ombudsman is a clearinghouse for complaints that has the authority to hold hearings and take action on behalf of a group of dissatisfied individuals, but when you are dealing with the complex bureaucracy that exists in the VA and DOD disability systems, you need someone there by your side helping you on your behalf. Whether that is an adversarial process or not is going to depend, in large part, on how the environment is created for the processing of those claims.

I would like to hear what institutional changes are being made within the DOD to make sure that adversarial environment is reduced.

Mr. DOMINGUEZ. Congressman, what I will tell you is that these are works in progress now. We have all heard the same thing that you have heard, that the process is cumbersome, bureaucratic, unfriendly, and it loses that focus on the soldier and the family around the wounded warrior. We all recognize we have to turn that around and we have to re-engineer the processes.

Now, several efforts are going on right now to look at that. Each of the services, as they have great discretion in how their process works, is working on that. There is training involved for the people that we put in to guide the warriors and their families through that process.

That is ongoing. We don't have all the solutions yet. We are working them aggressively.

As I said in my opening comments, when I leave here today I am going to join the leadership of the Veterans Administration with some of my colleagues from DOD, and we are beginning the redesign of the disability process for both our agencies and, again, hope to have that implemented expeditiously.

Mr. BRALEY. General Schoomaker, at the March 5th hearing I commended your brother for having the courage to say that PTSD is real. Part of the concern I have is when we label all of these measures with the words wounded warrior it brings about a history that has evolved over centuries of what it means to be a warrior and doesn't leave much room for people who suffer from post traumatic distress order or closed-hit injuries that are diagnosed as mild traumatic brain injuries, and give people the sense that there isn't a significant impairment that comes about to those individuals.

I admonished him at that time to make sure that message was communicated down the chain of command and into the DOD and VA health care treatment facilities to change that culture. Can you shed any insights on what is going on under your command to make sure that those injuries are treated and are perceived just as real as a penetrating injury?

General SCHOOMAKER. I appreciate the question and I think you are right on target. I think the Army, especially, has taken a very active and aggressive role in recognizing that we are in an era right now of emerging science and medicine in understanding the nature of injuries in their totality of 21st century war. Some of these injuries have undoubtedly been with us since warfare began and hostile conflict began. Others might be elements of the newer forms of urban warfare and the weapons that are being used against us and our soldiers, sailors, airmen, and Marines.

But the fact is the DOD has leaned forward as far as we can and needs to go further in understanding what it means to have mild traumatic brain injury. I think you heard that from the first panel here. We need some fast but good science to best understand that, and many of us have suggested that the new Walter Reed National Military Medical campus be a warrior care center of excellence to include work on that.

Fortunately, Congress, in the NDAO–6 legislation gave us language to coordinate, synchronize all research and treatment within the DOD under a blast injury program which is now being put together through the Army's Medical Research and Material Command, my last command.

I would have to also say that changing the culture is difficult, and we again are leaning forward as much as possible by getting leaders, leaders, themselves, leaders of war-fighting units coming back in the Marines and the Army, wherever they might be, to bring their soldiers with them as we do the mandatory screening for stress disorder-like symptoms, because those symptoms, if recognized and treated early, do not result in a lifelong, we believe, disability from PTSD and mild traumatic brain injury.

Mr. TIERNEY. Thank you.

The gentlewoman from Minnesota, Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chairman.

To followup on the PTSD and the traumatic brain injury, how often do you screen for that? If I have a loved one who comes to Walter Reed, how often are they evaluated for PTSD or traumatic brain injury?

General SCHOOMAKER. Well, ma'am, we screen as often as it is needed as often as symptoms dictate that we should be asking about that, but it is mandatory that every soldier, sailor, airman, Marine on deployment is screened prior to that deployment.

Ms. MCCOLLUM. The reason why I ask the question is—and I don't know if this is at all the VA centers, but the VA, every time one of our soldiers comes in now, has a screening that pops up that does a quick evaluation, not an in-depth, but a quick evaluation to see if that soldier might be facing post traumatic stress syndrome or traumatic brain injury that wasn't diagnosed right away. Are you doing that at the DOD?

General SCHOOMAKER. We don't have that tool, but we do have——

Ms. MCCOLLUM. I have some other questions.

General SCHOOMAKER. Yes, ma'am.

Ms. MCCOLLUM. And I don't mean to be rude by cutting you off.

General SCHOOMAKER. No, ma'am.

Ms. MCCOLLUM. I realize you are all talking to each other, so I am sure Mr. Dominguez is going to work with the VA to find out what they have, because if they have something we don't need to reduplicate the wheel.

Who places the DOD service personnel in the VA hospitals?

General SCHOOMAKER. That is on a case by case basis. In the case of a soldier coming back to Walter Reed or any of our facilities—and General Pollack may want to add to this—we have relationships with VA hospitals across the country in our local communities. We also have four large VA poly trauma centers.

Ms. MCCOLLUM. I wanted to know the DOD personnel—excuse me, I might have been too brief in asking my question—who is there to help a soldier who has been transferred to the VA system who still might be in the Department of Defense payroll, and to make sure that person has someone there who can answer questions. My understanding, and I will tell you this, is that there was one individual who was assigned to cover all the different branches of service, which all have different rules and regulations, at our VA system in Minneapolis, and the VA greatly appreciated having that individual there, but through no fault of the VA or the individual who had been assigned by DOD they rotated out every so many months. So I want to know do you know who is responsible for having that individual assigned to a hospital?

Mr. DOMINGUEZ. Congresswoman, we will have to look at that. We don't have that clear in policy.

Ms. MCCOLLUM. And I bring it up because I think it needs to be cleared up in policy.

There is a big difference between having a patient who has a case worker assigned to them, an advocate assigned to them, and an ombudsperson assigned to them. Those are three different roles. So you said that you have trained, Ms. Pollack, 23 people in the Army to be ombudspersons. Now, an ombudsperson is probably not

the first person you should start with, going through a system, because that person is going to be a pit bull against the Army for the patient, and I want to know what level this individual is really advocating for, because if they have to report back to the Army, if their promotion and everything is dependent upon the Army, it makes it very difficult to put somebody in a position to be at times aggressively in the face of the Army. So what have we trained here? More case workers? More general advocates to help with red tape? Or people who are going to be in the face of the Army on behalf of the patient?

General POLLACK. I think that in this position, ma'am, they will be in the face of the Army Medical Department, because it is the Army that wants it done, and therefore the Army will support them and they will be haranguing us inside the Medical Department if we are failing the soldiers. So I think that for the time being it is a good option. Many have raised the fact that now there are so many people engaged in the care of the patient, and that was one of the complaints that we had from the soldiers, that there were too many people engaged and they didn't know who their advocate was. They didn't know who to turn to. That is why I am very hopeful that, as we place the nurse case manager into position so that when the service member arrives at the facility they are assigned to a nurse that will be with them through their inpatient procedures as far as oversight, not the moment-to-moment care, but the planning and interaction with the family, and then continue with that service member through their entire transition process.

Ms. MCCOLLUM. Mr. Chair, can I ask for a qualification?

Mr. TIERNEY. Briefly, sure.

Ms. MCCOLLUM. OK. So what is the job title of these 23 people? Are they an advanced case manager? I mean, you just described case managers. Is that the 23 individuals that the Army has brought on?

General POLLACK. No. No, I was saying that there are people that are going to be very closely aligned with the service members as soon as they arrive and will stay with them, and I think that we are going to see over time that——

Ms. MCCOLLUM. Thank you. The Chair asked us to be brief.

If you could please provide to this committee what you are doing on these three different levels.

General POLLACK. Certainly.

Ms. MCCOLLUM. And who do they have to report for and how much autonomy that they have. Thank you.

Mr. TIERNEY. I thank the gentlewoman.

Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman. Again, thank you for holding this hearing.

General Pollack, there is a view that I hold and I think a number of other people hold that doctors do not really consider medical administration issues as part of their charge. I think you see that even in private hospitals, as well. In other words, doctors are for medicine and administration is for case managers.

What I would like to ask you is: what current policies or directives does the Medical Command have for medical administration

staff that work with patients? First, do you agree with that assessment? Second, if so, how do you want to deal with it?

General POLLACK. I would disagree with that assessment for the Medical Command, because the men and women that serve as our physicians are also volunteers, and they would not be there if they were not interested in caring for the men and women in uniform. So I have always seen them as advocates for our patients.

The nurse case manager that I raised a moment ago I think is part of that. What we are developing now is a triad with a physician, a nurse, and a line soldier, a non-commissioned officer, to be the group of three that is able to manage all the different pieces to ensure that patient can smoothly go through their transition and have everything coordinated. By bringing in the different perspectives, I think that we are going to have a much more satisfied population.

Mr. SHAYS. Then what accounts for the problems we have had?

General POLLACK. I'm sorry?

General SCHOOMAKER. What accounts for the problems that we have had? I mean, we know the problem exists. I was trying to identify why it might exist. So you tell me why it exists.

General POLLACK. Why does the problem in the dissatisfaction of the patient in the process?

Mr. SHAYS. Yes. And, well, first off, you can say it that way or we can say the fact that they deservedly can be dissatisfied because of what, and then tell me why.

General POLLACK. Well, I think that dissatisfaction is related to the length of the process. The challenge is in explaining to people sometimes why rehabilitation and the length of rehabilitation needs to be in a certain timeframe.

Mr. SHAYS. That is really not the problem. I mean, otherwise, you are saying that it is just a perception of the patient because they just don't understand how difficult this issue is.

General POLLACK. No.

Mr. SHAYS. And we have literally at one time close to 100 cases that this committee was trying to help with individuals who are getting lost in this administrative Byzantine process. We are well beyond that. I was trying to throw out the fact that I think doctors want to be doctors and they don't want to be administrators. It wasn't meant to be unkind, it was just meant to explain something. So if that is not the answer, is it because everybody is not communicating with each other because of paperwork and technology? What is it?

General SCHOOMAKER. Could I just make a comment, ma'am?

General POLLACK. Sure.

General SCHOOMAKER. With respect, sir, I think what I hear General Pollack saying is—and I think I need to say this, as well. One of the real heartbreaking aspects of everything we have gone through is that, whether you are a physician in uniform or a nurse or an administrator or whether you are an NCO, whether you are a civilian employee, we all like to feel very strongly that we are advocates for the patient. I think it speaks to how badly broken the system is right now that the patient at the end of the day and his or her family feels that we are all part of an adversarial system.

I think we all play a role in every case in trying to do best by these soldiers, ill and injured, irrespective of what the route of their injury or their illness is.

What we understand, and I think the point about the ombudsman I think points this out, is that we need as part of that plan to have, standing aside from the rest of us, because at the end of the day the patient and his or her family may feel that we are part of their problem, is to put someone in an ombudsman or a patient representative's role. At Walter Reed right now we have four patient representatives who are ombudsmen for patients who can bust through bureaucracy for them. They were there before. We didn't put enough emphasis on that role. We have three new ombudsman that General Pollack has brought in for us to serve in that capacity.

But I think the causes of what you have seen here, as the IRG has laid out, are myriad. We start at Walter Reed with the fact that we didn't have a primary care base system, and we are working on that.

Mr. SHAYS. My red light is on, and obviously we could probably go on since there is just three of us, but I would suggest to you that, you know, an ombudsman is helpful, but an ombudsman is someone who steps in when the system has broken down.

Could I make my motions now?

Mr. TIERNEY. Yes.

Mr. SHAYS. I mean, one of the things that it seems to me we need to be doing is we need to create, obviously, a Defense-wide ombudsman office that people can turn to. This is one of the suggestions that has come out of the work of our committee that you served on, as well, last time. I would like to submit this for the record. It is H.R. 1580.

Another one, this was actually advocated by Mr. Bilirakis this year. Another one is by myself and Mr. Davis, and this establishes a monitoring and medical hold over for performance standards. That is H.R. 1578.

Another is 1577, submitted by myself and others, and this is to create a Department of Defense wide program of patient navigators for wounded members of the armed forces, people who actually take on each individual patient and walk them through the process.

Finally, one to create a standard per-soldier patient tracking system that goes from one branch to the other.

I would just like to say I would love a hearing, Mr. Chairman, and I think that you would be inclined to want to look at it, and I think the committee is already, but just the hand off from the active armed forces to our veterans, because we are having just an abysmal time getting records of individuals once they go into the VA system. It is like somehow there aren't any records for our military personnel. You are not going to be holding on to these folks indefinitely. They are ultimately going to be veterans.

I know we are all wrestling with this issue but it actually took pictures to get the military to want to do something in the way that they are doing it now. It took pictures. Yet, I think as you know, Mr. Schoomaker, Building 18 does not define Walter Reed in one way or the other.

Thank you, Mr. Chairman.

Mr. TIERNEY. Without objection, copies of those bills will be added in the record.

[The information referred to follows:]

Wounded Warriors Joint Health Care Ombudsman Act (Introduced in House)

HR 1580 IH

110th CONGRESS

1st Session

H. R. 1580

To create a Department of Defense-wide Ombudsman Office.

IN THE HOUSE OF REPRESENTATIVES

March 20, 2007

Mr. BILIRAKIS (for himself, Mr. BUCHANAN, and Mr. SHAYS) introduced the following bill; which was referred to the Committee on Armed Services

A BILL

To create a Department of Defense-wide Ombudsman Office.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Wounded Warriors Joint Health Care Ombudsman Act'.

SEC. 2. ESTABLISHMENT OF A DEPARTMENT OF DEFENSE-WIDE OMBUDSMAN OFFICE.

(a) Establishment- The Secretary of Defense shall establish a Department of Defense-wide Ombudsman Office (in this Act referred to as the `Ombudsman Office') and assign the responsibility for overseeing the Office to the Assistant Secretary of Defense for Health Affairs.

(b) Functions- The functions of the Ombudsman Office are to provide assistance to and answer questions from medical holdover patients and their families regarding--

(1) administrative processes, financial matters, and non-military related services available to the patients and their families throughout the patient's evaluation, treatment, and recovery;

(2) transfer to the care of the Veterans Administration; and

(3) support services available upon the patient's return home.

(c) Additional Requirements-

(1) ACCOUNTABILITY STANDARDS- The Ombudsman Office shall--

(A) create and maintain case files for individual specific questions received, and initiate inquiries and track responses for all such questions;

(B) set standards for timeliness of responses; and

(C) set standards for accountability to medical holdover patients and their families, including requirements for daily updates to patients and family members about steps being taken to alleviate problems and concerns until problems are addressed.

(2) TOLL-FREE PHONE NUMBERS- The Ombudsman shall establish and maintain toll-free telephone assistance phone numbers as follows:

(A) One number shall be available for medical holdover patients and their families and shall operate 8 hours a day and 7 days a week.

(B) One number shall be available for medical emergency questions 24 hours a day and 7 days a week.

(3) STATUS REPORTS- The Ombudsman Office shall submit weekly status reports of actions taken to address individual concerns to the Secretary of Defense, the Secretary of each military department, and the inspector general of each military department. The Office shall also report to the commander or director of the office or facility with responsibility for the patients covered by the status report.

(d) Responses From Other Offices- The Secretary of Defense shall ensure that all other offices within the Department of Defense and the military departments respond in a timely manner to resolve questions and requests from the

Ombudsman Office on behalf of medical holdover patients and their families, including offices responsible for medical matters (including medical holdover processes), financial and accounting matters, legal matters, human resources matters, reserve component matters, installation and management matters, and physical disability matters.

(e) Briefings- The head of the Ombudsman Office shall conduct briefings of senior leadership in the military departments on all medical holdover trends, issues, and problems in person on a monthly basis.

(f) Congressional Inquiries- The Ombudsman Office shall be responsible for handling, and for setting standards regarding the handling of, all inquiries from Congress regarding medical holdover patients and other medical questions related to the Armed Forces. The Ombudsman Office may report about congressional inquiries to the congressional liaison headquarters of each military department.

(g) Staff of the Office-

(1) HEAD- The Ombudsman Office should be headed by a general or flag officer.

(2) STAFF- The Ombudsman Office shall be staffed by personnel from offices of the Surgeon General of each military department and also shall include representatives from each military department with responsibility for a part of patient processing and representatives from reserve components. Personnel in the Ombudsman office should--

(A) be highly trained in their office and command processes;

(B) be given standardized and updated information on all military retention facility personnel charged with on-location assistance; and

(C) in the case of military personnel, be assigned to the Office for a period of at least 3 years, and in the case of civilian personnel, be assigned to the Office permanently if practicable.

(3) TRAINING AND TESTING- Ombudsman personnel should be tested and evaluated on a standardized basis. Ombudsman personnel should be also trained to deal with members of the Armed Forces with post-traumatic stress disorder and other brain injuries.

(h) Medical Holdover Patient- In this Act, the term `medical holdover patient' means a member of the Armed Forces, including a member of the National Guard or other reserve component, who is undergoing medical treatment, recuperation, or therapy, or is otherwise in medical hold or holdover status, for an injury, illness, or disease incurred or aggravated while on active duty in the Armed Forces.

(I) Authorization- There is authorized to be appropriated to carry out this Act $2,000,000 for fiscal year 2007, and $1,000,000 for each of fiscal years 2008 and 2009.

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

TOM DAVIS, VIRGINIA
RANKING MINORITY MEMBER

ONE HUNDRED TENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143

Majority (202) 225–5051
Minority (202) 225–5074

Subcommittee on National Security and Foreign Affairs
Hearing on
"Is This Any Way to Treat Our Troops? – Part II: Follow-Up on Corrective Measures Taken at Walter Reed and Other Medical Facilities Caring for Wounded Soldiers"

April 17, 2007

WITNESS LIST

Panel I – Independent Review Group Chairmen and Members

- Honorable Togo D. West, Jr., Former Secretary of Veterans Affairs and Former Secretary of the Army
- Honorable Jack Marsh, Former Secretary of the Army
- Arnold Fisher, senior partner Fisher Brothers New York and chairman of the Board for the Intrepid Museum Foundation
- Lawrence Holland, senior enlisted advisor to the Secretary of Defense for Reserve Affairs
- Charles "Chip" Roadman, former Air Force surgeon general

Panel II – Department of Defense and Army Officials

- Honorable Michael L. Dominguez, Principal Deputy Under Secretary of Defense (Personnel and Readiness), U.S. Department of Defense
- Major General Gale S. Pollack, Army Surgeon General (Acting) and Commander, U.S. Army Medical Command (MEDCOM)
- Major General Eric Schoomaker, Commander, Walter Reed Army Medical Center

HR 1578 IH

110th CONGRESS

1st Session

H. R. 1578

To establish and monitor medical holdover performance standards.

IN THE HOUSE OF REPRESENTATIVES

March 20, 2007

Mr. SHAYS (for himself, Mr. TOM DAVIS of Virginia, Mr. BUCHANAN, and Mr. BILIRAKIS) introduced the following bill; which was referred to the Committee on Armed Services

A BILL

To establish and monitor medical holdover performance standards.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Wounded Warriors Joint Health Care Performance Metrics and Transparency Act'.

SEC. 2. ESTABLISHMENT AND MONITORING OF MEDICAL HOLDOVER PERFORMANCE STANDARDS.

(a) Requirement for Performance Standards for Medical Holdover Process- The Secretary of Defense shall assign the Assistant Secretary of Defense for Health Affairs the responsibility for establishing performance standards for each step of the medical holdover process, including the following:

(1) Mobilization.

(2) Medical condition.

(3) MNO decision.

(4) Disposition plan.

(5) Execution plan.

(6) Final disposition decision of a medical evaluation board or physical evaluation board.

(7) Transition.

(b) Quarterly Inspections-

(1) REQUIREMENT FOR INSPECTIONS- The Secretary of Defense, acting through the Assistant Secretary of Defense for Health Affairs, shall require each military medical installation to perform a quarterly inspection based on the performance standards established under subsection (a) of the following: command and control responsibilities, billeting, staffing, soldier administration, staff training, in and out processing, transition and separation processing, dining facilities and other non-medical patient services, transportation, medical case management, medical care, access and documentation, and medical database and medical records quality. Inspections teams should include representatives from all commands with jurisdiction over medical and administrative services provided to injured and wounded soldiers, and shall include representatives from the Department of Defense and the Inspector General of the Department of Defense.

(2) INSPECTION REPORTS- The Assistant Secretary shall require a report on each inspection carried out under paragraph (1) to be submitted to the Secretary of Defense, the Inspector General of the Department of Defense, each command or agency with jurisdiction, the Secretary of each military department, the chief of staff of each Armed Force, and the inspector general of each military department.

(c) Additional Specific Standards-

(1) SECURITY AND MEDICAL PERSONNEL- The Assistant Secretary of Defense for Health Affairs shall develop and enforce standards for security personnel and medical personnel to perform daily rounds of each medical inpatient and outpatient facility. The standards shall include a requirement for access to help 24 hours a day for patients with medical emergencies or needs.

(2) TIMELINESS- The Assistant Secretary also shall develop and enforce standards for setting time standards for responding to patient questions and scheduling appointments for medical evaluation board and physical evaluation board evaluations.

(3) PROCESSING- The Assistant Secretary also shall develop and enforce in-processing and out-processing standards, patient counseling

standards, and information standards to address patient and family members on all aspects of care, including medical and administrative evaluation procedures and requirements.

(d) Monthly Reports-

(1) REQUIREMENT- The Assistant Secretary of Defense for Health Affairs shall submit to the Secretary of Defense and the Inspector General of the Department of Defense a monthly report on military service performance in all categories of medical holdover patient care including, at a minimum, inspections, individual patient information, trends and problems, statistical information on time of patients in medical holdover status, performance of service commands, and other service personnel serving patients and families in medical holder status.

(2) ADDITIONAL MATTERS COVERED- The report also shall contain--

(A) information on all individual patient complaints and action taken to mediate the patient concern;

(B) information on all concerns raised by patient advocates to military service installation commanders and report on actions taken; and

(C) statistical information on the incidence, treatments, and outcomes of traumatic brain injury patients among the medical holdover patient population.

(e) Semi-Annual Meetings- The Assistant Secretary of Defense for Health Affairs shall meet semi-annually with the Secretaries of the military departments to address medical holdover program execution, including all medical and administrative issues, force structure, manning, training, and resource requirements.

(f) Inspector General Responsibilities- The Inspector General of the Department of Defense shall audit and review the medical holdover system and the performance standards developed under this section and shall submit quarterly reports to the Assistant Secretary of Defense for Health Affairs, the Secretaries of the military departments, and the following congressional committees:

(1) The Committees on Armed Services of the Senate and the House of Representatives.

(2) The Committee on Homeland Security and Governmental Affairs of the Senate.

(3) The Committee on Oversight and Government Reform of the House of Representatives.

(g) Medical Holdover Patient- In this Act, the term `medical holdover patient' means a member of the Armed Forces, including a member of the National Guard or other reserve component, who is undergoing medical treatment, recuperation, or therapy, or is otherwise in medical hold or holdover status, for an injury, illness, or disease incurred or aggravated while on active duty in the Armed Forces.

(h) Authorization- There is authorized to be appropriated to carry out--

(1) subsections (a) through (e) of this Act, $1,000,000 for fiscal year 2007; and

(2) subsection (f) of this Act, $2,000,000 for fiscal year 2007 and $3,000,000 for fiscal year 2008.

END

HR 1579 IH

110th CONGRESS

1st Session

H. R. 1579

To create a standard soldier patient tracking system.

IN THE HOUSE OF REPRESENTATIVES

March 20, 2007

Mr. BUCHANAN (for himself, Mr. BILIRAKIS, and Mr. SHAYS) introduced the following bill; which was referred to the Committee on Armed Services

A BILL

To create a standard soldier patient tracking system.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Wounded Warriors Joint Health Care Patient Tracking Act'.

SEC. 2. ESTABLISHMENT OF A STANDARD SOLDIER PATIENT TRACKING SYSTEM.

(a) Requirement- The Surgeons General of the military departments shall develop a joint soldier tracking system for medical holdover patients. The Assistant Secretary of Defense for Health Affairs shall have access to the tracking system of each military department for purposes of monitoring trends and problems.

(b) Functions-

(1) IN GENERAL- The tracking system developed under subsection (a) shall allow each medical holdover patient, each family member of such a patient, each commander of a military installation retaining medical holdover patients, each patient navigator, and ombudsman office personnel, at all times, to be able to locate and understand exactly where

a patient is in the medical holdover process.

(2) ADDITIONAL FUNCTIONS- The tracking system also shall be designed to ensure that--

(A) the commander of each military installation where medical holdover patients are located is able to track appointments of such patients to ensure they are meeting timeliness and other standards that serve the patient; and

(B) each medical holdover patient is able to know when his appointments and other medical evaluation board or physical evaluation board deadlines will be and that they have been scheduled in a timely and accurate manner.

(c) Matters Covered by Tracking System-

(1) IN GENERAL- Subject to paragraph (2), the tracking system shall contain, at a minimum, information on the following:

(A) The location of each medical holdover patient.

(B) The scheduled and anticipated appointments of the patient.

(C) The timelines and deadlines of the processes for evaluating the nature and extent of disabilities affecting the patient, including timelines of the medical evaluation board and physical evaluation board evaluating to the patient.

(D) Any other information needed to conduct oversight of care of the patient throughout the medical holdover process.

(2) PRIVACY EXCEPTION- Information relating to specific medical treatment or conditions, or other information with privacy concerns, may be withheld from the tracking system.

(d) Updating- The tracking system shall be updated daily by personnel that have access to the information described in subsection (c).

(e) Medical Holdover Patient- In this Act, the term `medical holdover patient' means a member of the Armed Forces, including a member of the National Guard or other reserve component, who is undergoing medical treatment, recuperation, or therapy, or is otherwise in medical hold or holdover status, for an injury, illness, or disease incurred or aggravated while on active duty in the Armed Forces.

(f) Authorization- There is authorized to be appropriated to carry out this Act

$2,000,000 for fiscal year 2007 and $4,000,000 for each of fiscal years 2008 and 2009.

END

HR 1577 IH

110th CONGRESS

1st Session

H. R. 1577

To create a Department of Defense-wide program of patient navigators for wounded members of the Armed Forces.

IN THE HOUSE OF REPRESENTATIVES

March 20, 2007

Mr. SHAYS (for himself, Mr. BUCHANAN, and Mr. BILIRAKIS) introduced the following bill; which was referred to the Committee on Armed Services

A BILL

To create a Department of Defense-wide program of patient navigators for wounded members of the Armed Forces.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Wounded Warriors Joint Health Care Patient Navigators Act'.

SEC. 2. ESTABLISHMENT OF DEPARTMENT OF DEFENSE-WIDE PATIENT NAVIGATOR PROGRAM FOR WOUNDED MEMBERS OF THE ARMED FORCES.

(a) Establishment- The Secretary of Defense shall establish a Department of Defense-wide patient navigator program and assign the responsibility for overseeing the program to the Assistant Secretary of Defense for Health Affairs.

(b) Function- Under the program, patient navigators shall be assigned as representatives to medical holdover patients and their families in order to improve health care outcomes.

(c) Qualifications of Patient Navigators- To qualify as a patient navigator, a

person shall successfully undergo extensive and regular training on all medical and administrative processes within the medical holdover system of the Department of Defense and specifically within the military installation to which the navigator is assigned. A person acting as a patient navigator may not be a member of the Armed Forces or an employee of the Department of Defense. The Secretary of Defense shall enter into contracts to acquire the services of patient navigators.

(d) Number of Patient Navigators- Under the program, there shall be a standard number of patient navigators at any military medical treatment facility or other medical retention facility, with the ratio of navigators to patients no higher than 1 to 10.

(e) Authorities of Patient Navigators- Under the program, the Secretary of Defense shall ensure that patient navigators--

(1) are allowed scheduled daily access to senior decision-making personnel and offices within the facility or military installation to which assigned;

(2) are informed of all corrective actions taken on behalf of the patients they represent in a timely, standardized manner; and

(3) are allowed access to patient medical scheduling information and allowed to assist in scheduling appointments in a timely fashion.

(f) Responsibilities of Patient Navigators- Under the program, each patient navigator shall--

(1) report in writing daily to the commander or director of the facility or military installation to which the navigator is assigned all patient and family concerns, issues, and complaints; and

(2) keep confidential all files, and have contracts with each patient acknowledging privacy and other patient concerns about the role of the navigator.

(g) Medical Holdover Patient- In this Act, the term `medical holdover patient' means a member of the Armed Forces, including a member of the National Guard or other reserve component, who is undergoing medical treatment, recuperation, or therapy, or is otherwise in medical hold or holdover status, for an injury, illness, or disease incurred or aggravated while on active duty in the Armed Forces.

(h) Authorization- There is authorized to be appropriated to carry out this Act $3,000,000 for each of fiscal years 2007, 2008, and 2009.

Mr. TIERNEY. Thank you, Mr. Shays.

General Pollack, I don't want to ask you a question on this but I just want to make a quick point on that. I think attitude is important, and I think that the report that was filed by the IRG had some comments to make on what has been happening in the past and also the leadership issues there. You were on record on March 13th indicating that the media, you sort of attacked the media, down-played the problems at Walter Reed, and I think your quote from your e-mail read that the media makes money on negative stories, not by articulating the positive in life. Then you added that you then went on to articulate your displeasure with the misinformation about the quality of care.

I hope that is an indication that you were trying to distinguish between those parts of the service that had been working will, but an acknowledgment, at least, that much has gone wrong, because if you are going to be the leader of this situation and now you are going to sit here and tell us that nothing is wrong in the face of the IRG report, our March 5th hearing, and the numerous other reports on that, I think I would be a little hard-pressed to think that you would be the person that should be responsible for fixing it.

General POLLACK. May I make a comment?

Mr. TIERNEY. If you would like, sure.

General POLLACK. The purpose of that e-mail was because the staff across the MEDCOM were reeling from all of the negativity, and we have men and women in and out of harm's way that have been working very, very hard, and it was my attempt, as one of the senior leaders, to remind them that they are doing a number of very good things and not to stop doing those things.

Sir, I joined the Army because my big brother had his leg blown off in Vietnam. I am very, very committed to the care of the men and women who serve. I am not going to pretend at any time if something is broken that it is not. But at the same time, I needed to reach out to the staff, and that was what the purpose of that e-mail was.

Mr. TIERNEY. So it is not an attempt at all to fail to acknowledge that there were things that need correction?

General POLLACK. No, sir.

Mr. TIERNEY. OK.

General POLLACK. No, sir.

Mr. TIERNEY. Thank you.

Mr. Dominguez, in your comments—and I think all three of you talked about it, as did the first panel—we are talking about senior leaders of the military departments, of the Office of the Secretary of State beginning the process of designing a system optimized for wounded and severely wounded service members, speeding disability determinations, and providing support for their transition to civilian life, which Mr. Shays was just talking about on that. What is going to be done in the interim for that while we are waiting for those final reports to come out? Is there anything we can do to make that transition better in the short run?

Mr. DOMINGUEZ. I think the steps that are being taken by the individual services are actually quite noteworthy in this regard, because a lot of the discussions that we have had here are about the patient advocates and case managers and ombudsmen. One of the

things that we didn't discuss, which both the Army and the Marine Corps have done, is put in for the wounded warriors a chain of command, assign them to a unit, give them a squad leader, give them a first sergeant, give them a commander. If you want a bulldog advocate for taking care of troops, it is called a first sergeant or squad leader.

Those are now going into place. Those people will have as their mission, the command's mission is helping that wounded warrior and family transition either back into service or back out to civil society. That is the kind of thing that closes the seams that Congressman Shays was talking about when he was identifying those different fixes.

The tragedy that these two officers were just talking about is the total commitment we have of people working inside their seams, believing that what they are doing is solving the wounded warriors problem, but not realizing that to the warrior, who is looking at this as a seamless process, that it is fragmented and broken and confusing.

Well, a CO, a first sergeant, and a squad leader can fix that. I think that is the most significant thing that has been done by both the Army and Marine Corps since your hearing on March 5th.

Mr. TIERNEY. Let me take it up a notch then on that. On page 6 of your testimony you say that we have invited representatives from the Veterans Administration to sit on the council to assist the process as we strive for a seamless transition for our service members from the Department of Defense disability system to the Veterans Administration system. We anticipate a revised Department of Defense instruction will be completed in May 2007.

Mr. DOMINGUEZ. Yes.

Mr. TIERNEY. So you are talking about the Department of Defense's instructions.

Mr. DOMINGUEZ. Yes.

Mr. TIERNEY. My question to you: has the President clearly indicated at his insistence that this be a seamless process, and has he communicated that to the Veterans Administration as well as to the Department of Defense, and has he designated somebody from the White House to so ride herd on this thing? Because you can get your Department of Defense instructions and the Veterans Administration can get its instructions. The question is: are they going to be joint instructions and is somebody from higher up going to give you license to cut across that and, in fact, insist on it?

Mr. DOMINGUEZ. Yes, sir. The President set up two commissions to advise him. First he put Secretary Nicholson in charge of an interagency task force and they have spoken on this issue. We are presently reviewing their recommendations. And then the President's Commission. So the President——

Mr. TIERNEY. You said a commission, but is there any indication that the White House has somebody who is going to be riding herd on this thing, an individual who is responsible, who this committee can hold accountable for making sure that is done, because I don't want to be sitting here criticizing the Department of Defense when it has done its work and it has given its instructions and the Veterans Administration has done its work and done its instructions.

Mr. DOMINGUEZ. Right.

Mr. TIERNEY. It will all come down to the White House as to whether or not they have them working together and giving them the support to do that.

Mr. DOMINGUEZ. Well, first of all, I conveyed to you Secretary Gates' and Secretary Nicholson's commitment to fixing this problem without regard to where the seams are. The President did put Secretary Nicholson in charge of the interagency task force, but, again, you know, the President can't specify what the answer is right now.

Mr. TIERNEY. He can sure make sure there is an answer.

Mr. DOMINGUEZ. But he took these two actions to bring to him the recommendations for how to fix this, and so from that I anticipate, you know, a powerful and strong action by the White House.

In the interim, our two agencies are working very closely together. I am going to join Under Secretary Cooper this afternoon, and we are working this problem. And Gates and Nicholson are passionate about getting this right.

Mr. TIERNEY. Do you, sir, agree that the physical evaluation, physical disability evaluation system should be completely overhauled to implement, one, Department of Defense level Physical Evaluation Board/Appeals Review Commission with equitable service representation in an expansion of what is currently the Disability Advisory Council, as the IRG recommended?

Mr. DOMINGUEZ. Sir, I would like to withhold my personal judgments on that pending the work that we are going to be doing evaluating the IRG's recommendations and the work we have already been doing for the last month or so.

Mr. TIERNEY. How long do you think it will take you to make that evaluation?

Mr. DOMINGUEZ. Secretary Gates will be back here on April 27th. I think he is scheduled to see the IRG, like, May 3rd or 4th. I expect he will want the DOD staff's recommendations to him about May 5th.

Mr. TIERNEY. Directly after May 5th I am going to ask that you communicate to the Secretary that one of you get back to the committee with whether or not they agree with that assessment of the IRG.

Mr. DOMINGUEZ. Yes, sir.

Mr. TIERNEY. And, if they agree that can be done, the process can be completed within 1 year, as was testified here this morning, and, if not within 1 year, what would be a reasonable time for us to expect it to be completed so that we can continue our responsibilities there.

Mr. DOMINGUEZ. Mr. Chair, if I might, one of the things that we are thinking about and just beginning the dialog inside the Department is for authority for the Congress to pilot on a subset of the population just that kind of thing. This is a complex system. We feel like if we could take something, put it in place, operate it for several months, that by this time next year we would have concrete, hard evidence from a process that worked that we could learn from and that we could come back to the Congress with very clear and detailed findings leading to legislation.

Mr. TIERNEY. I hope that, pilot or no pilot, that within a year or so we have some firm answers on that, but I hear what you are saying.

We have received reports, we have seen articles about some injured soldiers being given lowered disability ratings they say because the Army doesn't want to pay the 30 percent, the current maximum compensation, for a large number of permanently wounded soldiers. Have any of you investigated allegations of that nature? How are we going to have somebody accountable to make sure that is not happening?

General POLLACK. There is a review of that process going on now, sir. I don't have those specifics in front of me.

Mr. TIERNEY. Will you share them with the committee when you have a chance to get them?

General POLLACK. Yes, sir.

Mr. DOMINGUEZ. I do, sir, want to say this came up in testimony that Secretary Garon and Secretary England had before another committee of the Congress last week, and they were unequivocal in that our policy instructions are directives to these boards. That is not part of the calculus that they are supposed to be thinking about. This is to be what is the disability and how does it rate in the schedule and make a determination.

Mr. TIERNEY. I will look forward to General Pollack's response on that. I appreciate it.

Mr. Shays, if you will just bear with me 1 second, I have some unfinished business.

General Schoomaker, do you know if Staff Sergeant Dan Shannon had his reconstructive surgery scheduled yet, one of the witnesses in our first panel?

General SCHOOMAKER. Yes. I am trying to recall the status of him. I know one of the two soldiers has returned to Fort Campbell on active duty, Sergeant Duncan. I don't know the status of Shannon, but I can get back to you on that.

Mr. TIERNEY. Would you do that for us?

And can you tell us whether or not the Army has taken any steps to review the denial of benefits to Corporal McCleod? I recall that it was determined at one review that his brain function problems they said were the result of a pre-existing learning disability rather than a traumatic brain injury.

General SCHOOMAKER. I can check on that, sir.

Mr. TIERNEY. Could you see if that has been re-evaluated?

And Specialist Duncan has been returned to service, has he?

General SCHOOMAKER. As far as I know. I saw him last week or the week before, and he was on his way back to Fort Campbell. Yes, sir.

Mr. TIERNEY. Thank you.

Last question I have is about the problem that was testified to earlier, which I have heard in my District from some people involved with the psychological and psychiatric units, a declining number of mental health, behavioral staff in the medical system and some problems about out-sourcing some of that, contracting out, which these people that were talking to me did not feel was as good as having people within the service.

I know that the preliminary findings of the American Psychological Association that 40 percent of the Army and Navy active duty licensed clinical psychologist billets are presently vacant, and the IRG, of course, found that has affected the care and treatment of TBI and post traumatic stress disorder. What are we doing about that and what are we going to continue to do about that, if you would?

General POLLACK. Sir, we recently had approved at the Department of Defense level a critical skills retention bonus that we are implementing in 2007 to retain those officers. We have also established, because the behavioral health profession is so broad, we have instituted a master's of social work to assist with the, as well, and that program will begin in 2007, as well.

Mr. TIERNEY. Thank you. And one of the Secretaries made a point that if they are recruiting doctors over 50 they might have some success if they didn't impose the 8 year commitment rule. Is that being reviewed at all?

General POLLACK. Yes, sir. The G–1, the personnel community, is working that as a policy and as a legislative proposal, because I think we need relief. If I remember correctly, we need relief from a title 10 requirement.

General SCHOOMAKER. We approve of doctors over 50, sir.

Mr. TIERNEY. I approve of all people over 50. Thank you.

Mr. Shays.

Mr. SHAYS. Thank you. I just have a few questions.

Secretary Dominguez, Ellen Embry, the then Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, testified before this Committee on Government Reform in 2005 that DOD would direct all possible resources to address outpatient process. Why did this not happen, No. 1? Who dropped the ball? What will the Under Secretary do to see that he maintains oversight and input into policies that affect our war wounded?

Mr. DOMINGUEZ. Sir, unfortunately I am not able to tell you who dropped the ball. In terms of what we are doing——

Mr. SHAYS. Well, let's not answer the question who dropped the ball, but answer this: why did this not happen?

Mr. DOMINGUEZ. Why did this not happen? Well, I think there is some uncertainty, but many of us believe that a shortage of resources was not the issue, that there were adequate resources in the system to be able to deal adequately with outpatient care.

There were some real problems at Walter Reed, in particular, as you heard from the IRG, associated with BRAC and A–76 that, in the implementation of those program stuff, created a real capability gap that was noticed by patients and families and resulted in problems that we saw.

So I don't know that it was a resource problem, and I don't believe it was a policy direction and policy architecture problem. It manifested itself in execution at this one facility because of the perfect storm of events.

Mr. SHAYS. This is not a problem at one facility. Outpatient is a problem throughout.

Mr. DOMINGUEZ. Yes, sir, and as a result of the light shining on Walter Reed, all of the services sent people out to all of the facilities where they have——

Mr. SHAYS. I guess the problem that is discouraging is, you know, this was not a new problem. We documented it was a problem. We had people testify under oath that they would take care of the problem and the problem was not taken care of. You know, it makes you wonder.

Let me ask another question. The IRG recommends that the physical disability evaluation system must be completely overhauled to include changes in the U.S. Code, Department of Defense policies and service regulations resulting in one integrated solution. First, I want to know if you agree in one integrated solution. Then I would like to know your honest assessment of how this will be done and how long it will take and what resources will be needed.

That is the end of my questions, but I would like an answer.

Mr. DOMINGUEZ. Again, I think one integrated solution is one we absolutely, positively, clearly have to look at. I thank the IRG for putting it on the——

Mr. SHAYS. Look at does not mean have.

Mr. DOMINGUEZ. Yes, sir, because we are now evaluating the IRG's recommendations.

Mr. SHAYS. So you think you need to look at it, but you are not sure you need to do it?

Mr. DOMINGUEZ. At the current time I know we have to do something to change this process. It is not working. It is not working for service members and families. It is not doing what we——

Mr. SHAYS. How long is it going to take for you to decide you need an integrated system?

Mr. DOMINGUEZ. Sir, I think we are going to evaluate, in collaboration with the VA, we are going to look at designing that system, we are going to look at the statutory bases for the systems of disability that now work, which are different for the DOD, for the VA, and for the Social Security Administration.

We will see how you can reconcile those competing or those different policy objectives—they are coded in the statutes enabling these things—into one system, see how we can make that work, if we can figure out how to do that, honoring the statutory bases of the different calls that have to be made—are you fit to serve, or do we have to terminate your career, have you lost income, and are you unemployable.

So these different things have to be welded together into the system. We will see if we can make that work, and then we will come back with a proposal.

Mr. TIERNEY. If the gentleman would yield?

Mr. SHAYS. Yes.

Mr. TIERNEY. I understand from your earlier answer that by May 5th or immediately thereafter you are expecting to get back to us as to whether or not it can be combined into one, and then how much time you think it will take you to do that.

Mr. DOMINGUEZ. Yes, sir, we are going to try to move that expeditiously. I am hoping we do that by May 5th, because that is when we will have our conversation with Secretary Gates, and he will expect us——

Mr. SHAYS. What I would have thought the answer would have been would have been, one, we know we need to do it, we just don't

know how long it is going to take, and this is what we are going to do to figure out how long it is going to take.

Mr. DOMINGUEZ. Yes, sir.

Mr. SHAYS. But, you know——

Mr. DOMINGUEZ. I have to be able to assure you that in one system I can be true to the purpose that is enshrined in each of the statutes that provide a piece of the disability continuum that——

Mr. SHAYS. I asked one basic, simple question. How long will it take for the various hospitals, VA hospitals, to know that they can get records that are accurate about the servicemen and women that they are not treating?

Mr. DOMINGUEZ. Sir, if we have shared patients, I believe that is happening now with the bi-directional health information exchange that has been in place. We are sharing records. There are problems. There are, you know, many different pieces of a medical record. These two can be more specific about it, but that is a major effort, and we are sharing data on millions of patients right now with the VA back and forth.

General POLLACK. Sir, if I might?

Mr. SHAYS. Sure.

General POLLACK. There is significant progress that is promised at this time that by the end of the summer the VA and DOD should be linked. It will not be as clean as a simple click on your computer to move from one screen to another, because you will need to go into the other system and query, but General Schoomaker and I yesterday afternoon were briefed by Mr. Foster and his team from TMA, because this is a concern for us, as well, and there seems to be progress on this. But we will need to see it.

Mr. SHAYS. One is being able to share information within DOD and another to be able to share information between DOD and the VA.

General POLLACK. Yes, sir.

Mr. SHAYS. And in these United States, with such bright people and the resources that we should be able to put, it just seems to me it is more an issue of will rather than of anything else, just the will.

General SCHOOMAKER. Sir, we are assured that by the end of the summer that we will have bi-directional exchange of a large amount of the clinical record available to both the DOD and the VA system.

Mr. DOMINGUEZ. And there is a significant technological challenge here, Congressman. There is the will. There is actually commitment by the leadership of VA and DOD to make this happen. It is a challenging problem and we are working on it very hard.

We are not, by any means, where we need to be as a Nation.

Mr. TIERNEY. Before we wrap up, we asked for a number of records in a previous request back on March 5th, or whatever, and unfortunately this is all we have received so far, which is obviously quite inadequate for that, and a considerable amount of time has passed. Do we have your assurance? And who is going to take responsibility to make sure that those requests are completed in full and promptly?

Mr. DOMINGUEZ. Yes, sir.

Mr. TIERNEY. General Schoomaker.

General SCHOOMAKER. I will have the first delivery of those documents to you this week, sir.

Mr. TIERNEY. Well, when is the last delivery going to come? I mean, this is the first delivery, I guess. When can we expect that we will have it? Within a reasonable period of time here?

General SCHOOMAKER. Yes, sir. I think I will have——

Mr. TIERNEY. We are already beyond a reasonable period of time, so now we are going to give you a second reasonable time, if we can.

General SCHOOMAKER. I understand, sir.

Mr. TIERNEY. Thank you.

Thank you all for your testimony. Thank you for your service to your country, as well. We don't mean to be individually tough on you, specifically, but I think you share our need to be tough on this issue, and we appreciate your willingness to cooperate. Thank you.

[Whereupon, at 12:55 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

SUGGESTIONS FOR IMPROVING SERVICE TO WOUNDED WARRIORS

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A recent two-part article in the Washington Post uncovered a number of problems affecting the management of wounded warriors who were receiving post-discharge care at Walter Reed Army Medical Center in an outpatient status. The issues raised involved administrative and logistic matters; the actual medical care provided to wounded warriors was felt to be excellent. These revelations have led to intense public concern and have instigated a series of follow-up investigations, Congressional hearings, and personnel actions.

This memo outlines some preliminary suggestions for correction of these deficiencies and improvement in the management of wounded warriors. The proposals described below are based on my twenty years experience as a military physician at Walter Reed, encompassing the evaluation and treatment of thousands of soldiers (including assessment of their fitness for duty); my eight years experience as a legislative assistant in the U.S. Senate handling health and veteran issues (including constituent cases involving disability evaluations from both the military and the Department of Veterans Affairs); my review of pertinent laws, regulations, policies, and reports; and my personal involvement with this system, both as a member of Medical Evaluation Boards and Physical Evaluation Boards as well as my experience as a soldier evaluated for disability by both the Army and the Department of Veterans Affairs.

The Washington Post series and the ensuing developments have indicated that the problems noted at Walter Reed fall into three general categories: inadequate building maintenance; disorganized administrative handling of wounded warriors after hospitalization; and a dysfunctional disability evaluation system. This paper focuses on the latter two concerns, under the assumption that the building maintenance issues can be handled by current procedures given appropriate leadership and resources. In particular, I have concentrated on those problems whose correction would require systemic alterations rather than those which could be fixed by changes in resource allocation or in assignment of specific personnel. The overall approach of these proposals is:

- to decentralize the provision of post-hospital care in order to relieve the strain on individual facilities and to provide wounded warriors with more choice in their living arrangements (items 1, 2, 3);
- to consolidate and centralize the military disability evaluation system in order to enhance consistency and efficiency (items 4, 5, 6, 7);
- to restructure the Physical Evaluation Board in order to increase the expertise of its members and to improve its efficiency and user-friendliness (items 8, 9, 10, 11, 12);
- to postpone final disability determinations until medical conditions are stable in order to increase accuracy and fairness for wounded warriors (item 13);
- to provide for continuous updating of standards for medical unfitness and percentage disability ratings in order to improve the precision of individual disability assessments in an era of rapid advances in medical knowledge and evolutionary changes in the nature of warfare and service-related injuries (item 14).

ISSUE: IMPROVING POST-HOSPITAL CARE

1. NEW ADMINISTRATIVE CATEGORY: EXTENDED CONVALESCENT STATUS

Background:

Many wounded warriors who are discharged from Walter Reed Army Medical Center are assigned administratively to a Medical Holding Company or Medical Holdover Company at Walter Reed while they obtain outpatient care and go through disability evaluations. These warriors live in barracks on-post and are often utilized for light-duty work on the base. A number of warriors in this situation have their families with them at Walter Reed. It is not uncommon for wounded warriers to remain in these medical holding units for many months, even up to a year or longer.

News reports indicate that wounded warriors are very unhappy at being kept in medical holding units at Walter Reed for long periods away from their homes. In addition, questions have been raised about whether such wounded warriors have been given inappropriate work assignments in order to make up for personnel shortfalls at the facility.

Proposal:

After being discharged from the hospital, wounded warriors should be placed in a new administrative category termed Extended Convalescent Status. This new category would be modeled on the current Convalescent Leave status, but of longer duration. Wounded warriors in Extended Convalescent Status, like those on Convalescent Leave, may reside where they desire, are not under close administrative supervision (e.g. no daily formations or reporting), and would not generally be required to perform military duties. While in Extended Convalescent Status, wounded warriors are expected to focus on achieving medical recovery and on completing disability processing.

Wounded warriors who lack a robust support network of family and friends, as well as those with medical conditions such as traumatic brain injury or post-traumatic stress disorder that may render them in need of greater hands-on assistance in managing their follow-on therapy (e.g. remembering and getting to medical appointments), would have the option of living on-post at Walter Reed, or other appropriate military treatment facility, with their families.

Wounded warriors on Extended Convalescent Status who miss appointments or otherwise fail to comply with military requirements can be removed from Extended Convalescent Status and may be required to reside on-post at a specified military treatment facility under close supervision.

2. MILITARY DISCIPLINE DURING EXTENDED CONVALESCENT STATUS

Background:

Recent investigations indicate that delays in medical recovery and in finalization of the administrative status of wounded warriors may be related, in part, to missed appointments. Such actions may reflect poor supervision, inadvertent oversight, or deliberate non-compliance. The Army Inspector General has reported that soldiers who are on the Temporary Disability Retired List (TDRL), an extended administrative status not dissimilar from the proposed Extended Convalescent Status, have often missed their scheduled follow-up examinations. The Inspector General also noted that the ensuing loss of military pay and benefits did not seem to deter this behavior; the soldiers look to disability payments from the Department of Veterans Affairs (VA) as a means of support. Similar problems, resulting in a prolonged recovery/evaluation process, might be anticipated for some of those wounded warriors placed in the relatively unsupervised category of Extended Convalescent Status.

Proposal:

Wounded warriors will be extensively counseled that, despite the relative freedom granted to them while in Extended Convalescent Status, they remain on active duty and are expected to keep all appointments for medical care and disability processing and to comply with all other military orders, rules, and regulations. As noted previously, violations of these policies may subject wounded warriors to removal from Extended Convalescent Status, with return to strict military supervision in an on-post setting. Persistent infractions can lead to military disciplinary actions (e.g. non-judicial punishment) and may also result in downgrading of discharge status (e.g. general vs honorable), which can impact eligibility for veterans benefits. It will be emphasized to wounded warriors that granting of Extended Convalescent Status comes with both privileges and obligations: the freedom to live where they want without military supervision or military duties is designed to enable them to focus on their medical recovery and administrative processing.

3. MULTIPLE NEW WOUNDED WARRIOR CENTERS

Background:

Wounded warriors evacuated from overseas are generally hospitalized at military medical facilities in the Washington, DC area, such as the Walter Reed Army Medical Center or the National Naval Medical Center, and they often obtain their follow-on outpatient care from these same facilities. This system results in many wounded warriors having to remain in the DC area, away from their homes, for long periods of time. In addition, concentration of wounded warrior care at a small number of facilities has put an enormous strain on these facilities, greatly exacerbating the problems that have been described in recent news stories.

Proposal:

The Department of Defense (DOD) should designate several Wounded Warrior Centers: specific sites resourced by DOD and VA to provide wounded warriors with all required DOD disability processing and all needed medical care. These sites initially might include all major military medical centers as well as the four VA polytrauma centers. Based on current facility locations, such a framework would designate Wounded Warrior Centers in CA, DC, FL, GA, HI, MD, MN, MS, OH, TX, VA, and WA, thereby providing broad geographic coverage.

Wounded warriors who are discharged from the hospital can seek further outpatient medical care and disability processing from any of these Wounded Warrior Centers, including the facility from which they were discharged. Wounded warriors and their families would thus be free to remain at their initial medical location (for example, if they desired to continue with the same medical personnel that provided their inpatient care) or to move their care to another Wounded Warrior Center of their choice (for example, one closer to home or to relatives).

All wounded warriors on Extended Convalescent Status are free to reside where they like, but their choice of living arrangements must take into account the requirement to go to a Wounded Warrior Center for all needed appointments. To facilitate these logistics, wounded warriors would be provided with the option of on-post housing at any military Wounded Warrior Center.

As an example, a wounded warrior originally from Ft Benning, GA, who is discharged from Walter Reed, would have several living options during Extended Convalescent Status: 1) continue to live on-post at Walter Reed; 2) return to home at Ft. Benning, with travel as necessary for appointments at the Wounded Warrior Center at Eisenhower AMC, Ft Gordon, GA; 3) live on-post at Ft. Gordon, with appointments at Eisenhower AMC; 4) live with parents in San Diego, with follow-up appointments at the Wounded Warrior Center located at the Naval Medical Center there.

In very limited circumstances, a wounded warrior with a unique and particularly complex medical condition or administrative situation could be required to go to a specific military tertiary care center (e.g. Walter Reed) for medical care and administrative processing rather than to other Wounded Warrior Centers.

ISSUE: MODERNIZING DISABILITY PROCESSING

4. NEW DEPARTMENT OF DEFENSE PHYSICAL DISABILITY AGENCY

Background:

Each military service currently runs its own disability processing system for wounded soldiers. This decentralization leads to multiple sets of disability rules, despite DOD requirements for

uniformity, and also results in logistic inflexibility: an Army soldier cannot be processed by the Air Force disability system, even if the Army disability system is totally overloaded and the Air Force system is underutilized. As a result, a wounded warrior's disability processing is limited to a very small number of service-specific locations, leading to significant inconvenience for the individual. In addition, each military service has to duplicate a set of disability specialists and cannot share them across services.

Proposal:

DOD should establish a new agency, the Defense Physical Disability Agency (DPDA), reporting to the Undersecretary of Defense for Personnel and Readiness. This agency will provide disability processing for military personnel of all services and will operate under a single set of disability rules and procedures that applies to members of all military services.

Wounded warriors should be able to receive appropriate disability processing through DPDA personnel at any of the Wounded Warrior Centers, irrespective of the warrior's original branch of service. DPDA personnel will be trained to handle disability processing for warriors holding service-specific jobs (e.g. diver) as well as those with jobs that are similar across services (e.g. clerk). Establishment of a multi-service DPDA will be essential if wounded warriors are going to be permitted to obtain all of their medical care and disability processing through a Wounded Warrior Center that is not part of their parent service. Creation of a unified DPDA also permits sharing and maximal utilization of key disability personnel.

5. COMPREHENSIVE TRACKING SYSTEM FOR DISABILITY PROCESSING

Background:

The military disability processing system is complex and convoluted, and completion of disability evaluations is often delayed. Tracking of individuals through this system, something necessary for timely completion of processing, has been incomplete and not user-friendly.

Proposal:

DPDA should establish a web-based computerized tracking system for individuals undergoing disability processing. This system should delineate what steps each wounded warrior has completed, what additional actions have been scheduled, and what procedures remain to be scheduled. Such computerized records could include both administrative actions (e.g. completion of disability counseling) as well as medical actions (e.g. orthopedic consultation scheduled). This information should be made available via secure Internet means to all personnel involved in managing the wounded warrior during the disability evaluation process.

6. UNIFORMITY OF DUTY FITNESS EVALUATIONS WITHIN AND BETWEEN MILITARY SERVICES

Background:

The separate military services have quite different systems and procedures for evaluating an individual's medical fitness for duty, and even within a single military service, there may be more than one system that assesses whether an individual's ability to perform the duties of his/her job is impacted by a medical condition. These multiple parallel systems lead to inconsistency and confusion.

For example, the Army has two separate administrative systems which evaluate a soldier's medical fitness to perform the duties of his/her job: the Physical Evaluation Board (PEB) and the MOS [Military Occupational Specialty] Medical Retention Board (MMRB). If medical personnel believe that a wounded warrior has a medical condition that renders him/her unfit to perform the duties of the current job, the individual will be referred to the PEB, which will ultimately make a decision either to return the warrior to his/her job or to remove the individual from military service (separation or retirement).

In contrast, if Army medical personnel determine that a wounded warrior has a significant medical condition (severity rated 3 or 4 on a 1-4 scale), but they do not feel that he/she is unfit for duty as defined by regulations, that individual will be referred to the MMRB. The MMRB can then take several actions: validate the individual's fitness for the current job; decide that the medical condition renders the individual unfit for the current job but recommend reclassification to a different job; or refer the individual to a PEB for separation from the military.

There is clearly overlap between the functions of the PEB system and the MMRB system, and the Army Inspector General has reported widespread confusion about the roles of the two systems among medical and non-medical personnel at all levels. By contrast, the Navy does not have an MMRB system.

Proposal:

The work of the DPDA should be closely coordinated with all service-specific systems for evaluating the fitness for duty (e.g. the Army's MMRB system). All personnel must be given clear instructions regarding when to use each system. Ideally, all systems for evaluation of fitness for duty should be identical among the military services. Consideration should be given to merging all such service-specific systems directly into DPDA to establish uniformity and maximize efficiency.

It may be desirable to set up a procedure under which wounded warriors who are found by DPDA to be medically unable to perform the duties of their current job should be offered the voluntary opportunity to reclassify into a different military position, in their own military service or in one of the others, for which their medical condition does not pose a limitation.

7. SEAMLESS DOD-VA COOPERATION ON DISABILITY EVALUATION

Background:

DOD and VA use dissimilar disability evaluation systems, forcing wounded warriors to go through disability processing twice. Medical information is not readily transferred between DOD and VA. DOD and VA often repeat medical studies done by the other agency. Such duplication and inconsistency is very disruptive to wounded warriors and is highly inefficient.

Proposal:

DOD and the VA must work closely together on disability evaluation to make the overall process seamless and more user-friendly. For example, DPDA personnel could be assigned to work out of VA facilities and VA disability personnel could work out of DOD facilities; wounded warriors could then handle both DOD and VA processing at one location. Electronic medical records should be configured to permit ready transfer of information back and forth between DOD and VA. DPDA should accept all medical evaluations, studies, procedures, and information established by VA medical personnel, and conversely the VA should accept similar information from DOD physicians. DPDA should automatically refer all completed actions on wounded warriors to VA for initiation of processing for VA disability determination and compensation.

ISSUE: OPTIMIZING PHYSICAL EVALUATION BOARD OPERATIONS

8. INCREASED SIZE OF THE PHYSICAL EVALUATION BOARD

Background:

The Physical Evaluation Board (PEB) is the group that determines whether a wounded warrior is medically unfit for military service (i.e. unable to perform the duties of his/her current job as a result of a medical condition), and it also establishes a percentage disability rating for those found unfit. At present, the PEB is composed of three voting members: one President and one Personnel Management Officer, who are line officers, and one physician.

The small size of the PEB gives rise to a relative limited breadth of experience in evaluating the fitness for duty of wounded warriors who may hold a wide variety of specialized jobs. For example, a PEB composed of an infantry officer, an artillery officer, and a physician may have a lot of experience in assessing the duties of an infantryman, but limited experience in assessing the job requirements of a nuclear reactor repairman.

Proposal:

The size of the PEB should be expanded to a minimum of five members to broaden the depth of experience. Current Army Regulations already require PEBs for enlisted personnel to have five members. A larger PEB size will also simplify meeting the membership criteria for PEBs as regards presence of women, minorities, enlisted personnel, and reservists.

9. MAXIMAL USE OF CIVILIANS IN MILITARY DISABILITY PROCESSING

Background:

At present, most Physical Evaluation Boards (PEBs) are staffed by line officers assigned to the PEB for a few years at a time. This personnel turnover leads to loss of institutional memory and inconsistency. Line officers may not have as much expertise in disability evaluation as full-time disability evaluation professionals. In addition, use of line officers for PEBs takes them away from their primary military duties during a time of war.

Proposal:

To maximize consistency, the PEBs should ideally be composed primarily of civilian disability professionals. Of note, existing Army regulations already permit PEB positions to be filled by civilians. For the same reasons, the DPDA should be primarily a civilian agency with a stable workforce of disability professionals, similar to disability organizations run by the Department of Veterans Affairs and the Social Security Administration. Just as civilian disability professionals can be trained to understand the details of a wide variety of civilian jobs without having performed those jobs, they can also be trained in the details of diverse military occupational specialties. This process can be facilitated by giving preference to those with military background, especially military retirees, for civilian positions on the PEBs or in DPDA.

10. BRANCH-SPECIFIC MEMBER OF PHYSICAL EVALUATION BOARDS

Background:

In order to perform their essential role of assessing a wounded warrior's ability to perform the duties of his/her job, the Physical Evaluation Board (PEB) must be familiar with that individual's military duties and assignments. As the membership of PEBs is changed from military officers to highly-trained civilian disability professionals, as outlined above, the function of the PEB could be enhanced even further by having a PEB member who has direct familiarity with the wounded warrior's military occupational specialty.

Proposal:

One member of each PEB should be from the same military service and branch as the wounded warrior being evaluated.

11. SPECIALTY PHYSICIANS ON PHYSICAL EVALUATION BOARDS

Background:

Frequently, the physician member of the Physical Evaluation Board (PEB) is a single individual who works full-time for the PEB and serves on multiple PEBs. In the 21st century, it is highly unlikely that one physician would possess all of the knowledge, skills, and abilities needed for proper evaluation of the wide variety of complex medical conditions that may come before the PEB.

Proposal:

The physician member of the PEB should ideally be of the appropriate specialty corresponding to the wounded warrior's medical condition. Both the military and the wounded warrior are best served if the PEB physician is very familiar with medical problems of the type faced by the wounded warrior.

12. VIDEOCONFERENCING OF PHYSICAL EVALUATION BOARDS

Background:

Currently, Physical Evaluation Board (PEB) members must be present in a single geographic location, and the wounded warrior must be at that same location during formal PEBs. The requirement for face-to-face contact is a great inconvenience to the wounded warrior and it limits the pool from which PEB members can be drawn. This problem is exacerbated if, as outlined above, there is a new requirement for the PEB physician to be of appropriate specialty and for one PEB member to be from the wounded warrior's service and branch.

Proposal:

PEBs should maximize the use of videoconferencing for all functions, replacing face-to-face meetings. Videoconference centers are now widely available throughout the country. Of note, Medicare uses videoconferences extensively in its appeals process. Use of videoconferencing would minimize the need for travel by the wounded warrior, and it will also greatly facilitate meeting the various requirements for PEB membership regarding physician specialty, gender, race, enlisted status, component, service, and branch.

For example, with the use of videoconferencing and coordinated centralized PEB scheduling, including grouping of PEBs according to medical condition and warrior job, one civilian orthopedic specialist located in Washington DC could, in a single day, serve as a member of several PEBs taking place throughout the country, thus providing specialty-specific expertise in an efficient manner. Likewise, one submarine officer in San Diego could participate in multiple PEBs on a single day in order to provide the needed branch-specific expertise.

ISSUE: IMPROVING FAIRNESS OF PERCENTAGE DISABILITY RATINGS

13. REQUIREMENT FOR STABILITY OF MEDICAL CONDITION

Background:

Under current rules, if a Physical Evaluation Board (PEB) finds a wounded warrior medically unfit for service, the PEB then assesses a percentage disability rating, using a set of criteria called the VA Schedule for Rating Disabilities (VASRD). The general rule is that an individual with a disability rating of 30% or higher is eligible for a medical retirement, which includes not only a monthly pension from DOD but also full retirement benefits (commissary, PX, medical care for self and dependents through TRICARE). Individuals with a disability rating of less than 30% are separated from the military with a lump sum payment and without other retirement benefits.

In cases where the initial disability rating is 30% or higher, the PEB is allowed to take into account the possibility that the wounded warrior's condition is not stable: it might worsen, justifying a higher disability rating, or it might improve, allowing a return to active duty. Individuals initially rated as 30% or higher whose medical conditions are not stable are placed on the Temporary Disability Retired List (TDRL) and are followed with repeated examinations; a final determination of fitness for duty and disability rating is not made until the medical condition is stable.

By contrast, in cases where the initial disability rating is less than 30%, the PEB does not take into account whether the wounded warrior's condition is stable: the warrior is separated with a lump sum payment and no benefits, even if the medical condition might have worsened to a disability rating of 30%, thereby justifying a military retirement with full benefits, or might have improved, thereby resulting in a return to duty. Individuals rated less than 30% disabled are not eligible for placement on TDRL to determine the stability and final outcome of their medical conditions.

This situation is unfair to the wounded warrior and to the military service, and the inconsistent treatment of those with disability ratings above and below 30% is an ongoing source of confusion.

Proposal:

Regardless of initial disability ratings, PEBs should not make final determinations on fitness for duty or percentage disability rating unless and until the wounded warrior's medical condition is confirmed to be stable. Any wounded warrior found to be medically unfit for active duty, whose medical condition is not stable, should be placed on the TDRL until the medical condition stabilizes.

An exception to this policy is appropriate for wounded warriors who are found medically unfit for active duty, whose initial disability ratings are 30% or higher, and whose medical condition is extremely unlikely to improve. These wounded warriors may be given a permanent medical retirement, with full benefits, even though their medical condition is not stable (i.e. worsening). Such individuals will be eligible for later updating of the initial percentage disability rating awarded by DOD as their medical condition changes.

14. CONTINUOUS UPDATING OF STANDARDS FOR MEDICAL FITNESS AND CRITERIA FOR PERCENTAGE DISABILITY RATING

Background:

The determination by a Physical Evaluation Board (PEB) that a wounded warrior is medically unfit for duty is based on its finding that the service member has one of a specified list of medical conditions (Army Regulation 40-501 and corresponding rules for other services). After the PEB finds that a wounded warrior is medically unfit for service, it establishes a percentage disability rating using the VASRD (Title 38, Part 4, Code of Federal Regulations) along with service-specific modifications to VASRD.

Revision of both of these standards has been slow, often lagging behind the rapid progress in our understanding of medical conditions as well as the evolving nature of modern military duties and the changes in the type and severity of injuries incurred in modern warfare. The current disability rating scheme has been particularly criticized in the case of wounded warriors with impairments that are not visually obvious, e.g. traumatic brain injury and post-traumatic stress disorder, or in those disabled by symptoms, such as pain, that are primarily subjective. Use of outdated standards is unfair to the wounded warrior and to the military.

Proposal:

A robust mechanism should be established for the continuous and expeditious updating of the standards of medical fitness for service on active duty (Army Regulation 40-501 and corresponding rules for other services) and the standards for rating disabilities (VASRD). Ideally, a single set of such standards should apply to the VA and to all military services.

Name: Gary D. Knight

Your Message: Members of the House Oversight and Government Reform Committee:

Ladies and Gentlemen:

I have my own Walter Reed horror story. I not only was born in Bethesda Naval Hospital, but received my physical for the Naval Academy, and spent the last six months of my active duty service there prior to being medically retired in 1971. So I know what good military medical care is. However, in late 1990 I needed a small (overnight) medical operation done and all the Navy docs were aboard the USNHS Comfort awaiting Gulf War I to start, so I was sent to Walter Reed the first week of 1991 for the procedure.

The procedure was routine and typically, I forced myself to come out of the anaesthetic in half the time of the average patient, so I could get out of there, but they shipped me up to a hospital room for an overnight stay. There were 5 or 6 men in the room which was a pig stye. It literally had not been cleaned in over a week (the guy in the next bed said he'd been there 5 days and he'd yet to see anyone come in to clean) and there were large dust bunnies and piles of trash in every corner. Worse, there was dried snot all over the large mirror over the sink, which was in the room, not in a separate bathroom.

They wheeled in a liquid dinner for me to consume and while doing so the IV, which had still been in the back of my hand, started spurting blood. It took me three or four times pushing the nurses' call button before I even got a response. When it came, it was a nasty and harsh, "Whaddya want?" When I related the problem, I got a deep sigh and a "Wait a minute, dammit!" When the Army nurse finally came she was attitude personified and said I ddn't need the IV anymore anyway and yanked it the rest of the way out. She was beginning to walk away when I asked her if she at least had a wet rag or something to wipe up the blood off myself and my bedclothes, and she viciously waved at the sink. Mind you, my artificial leg was standing next to the bed and there's no way she could have missed it and strapping it on involved my getting more blood all over it and myself; I was supposed to be recuperating from a surgical procedure that was serious enough that they had to put me
under; and I was supposed to be consuming a meal to restore my strength. I was livid.

When the Doc came through on rounds an hour later, I still had steam coming from my ears. I told her I wanted out of this chicken*&%# hole and I wanted out now! She shook her head, but her superior was with her and when he looked at the intense look on my face, he asked if I could drive, and I said "You bet your sweet ass I can." So he overruled her and wrote an order discharging me. The next day I wrote a vicious but respectful letter of complaint to the Walter Reed CO saying that he better get the hospital a little more shipshape before the wounded troops started getting shipped back from Kuwait/Iraq as it was presently UNSAT. He responded with a typical CYA bureaucratic

piece of pablum that I wished I'd saved. Needless to say, I vowed that I'd rather die on the street rather than go into that hellhole again.

The news reports about Walter Reed's abyssmal condition did not surprise me one damned bit. The cleanliness and more important the attitude of the personnel all start with the CO, and it appears that the mindset of Walter Reed's COs hasn't changed one iota in the past 15 years! And this was in the in-patient portion of the hospital.

I respectfully request that this communication be included as part of the formal hearing record.

Sincerely,
Gary D. Knight

Testimony of Officer Patrick Hayes Submitted for the Official Record at the National Security and foreign Affairs Subcommittee hearing on:
"Is This Any Way to Treat our Troops?-Part II:
Follow-up on Corrective Measures Taken at Walter Reed and Other Medical Facilities Caring for Wounded Soldiers"

Thursday, April 17, 2007

I would like to submit the following as my testimony concerning the terrible conditions at Walter Reed Hospital and the fact that the Police force is forbidden by the Department of the Army and The Command at Walter Reed from arresting civilian criminal violators and that we are routinely instructed to release civilian violators on instant bar letters and no charges if the D.C. police do not assume jurisdiction of them. We are told that we have no arrest power whatsoever and basically we are treated as less than guards. Prior to September 11th, 2001 we had a memorandum of understanding signed in 1997 with the D.C. Police that allowed us to arrest and process civilian criminal violators utilizing D.C. paperwork and facilities. Shortly after 9-11 we were instructed to not arrest civilians anymore and to call the D.C> police.

The Department of the Army and the Command of Walter Reed state that we have never had arrest powers and that we can only detain civilians and military offenders and release them to either civil or military authorities. We cannot even stop a crime in progress outside of our gates and are forbidden to intervene even if we see the crime being committed.
The Command and the Department of Army have included us by their policy not law under the restrictions of the Posse Commitatus Act of 1878 which forbids under Title #10 USC military troops from enforcing laws against civilians. The Command and the Army states that we are not even Federal Police, that we are civilian employees with limited police power confined to the Installation, Even though we are all hired under the OPM GS-0083 Federal Police series and trained and equipped and wear uniforms and weapons and drive marked police vehicles.

Whoever heard of Police that cannot arrest? If I were to be assaulted in full uniform by a civilian violator, I have to call the local police and hope that they arrest the individual. if not just take them to the gate and let them into the local community without charges. If I cannot arrest someone that would strike a uniformed police officer, how can I protect anyone?

The Department of Army will not even allow us to be commissioned as Special Police Officers to make arrests, if it is in fact true that we do not have statutory police powers of arrest. Yet if we do not have arrest powers then why do we and I on many occasions have responded to calls for police service on the installation and have taken civilians and military personnel against their will, handcuffed, transported in a marked police vehicle to our station, BLDG # 12, Where we advice them of their rights, Keep them for hours, Take statements, process them on Military police paperwork and then release them which is according to the U.S. Supreme Court and the United States Constitution an arrest. The Army and our Command call it a brief detention. I feel as though I

am violating the Constitution by willfully arresting people that the Command and The Army have no intention of prosecuting.

The Command at WRAMC would rather we just issue numerous parking tickets, D.C. notices of infraction against the soldiers and staff to include the wounded warriors at BLDG # 14, BLDG # 20 the Mologne Hotel, BLDG # 6 the Dept. of psychiatry, The patient parking garage and all the open parking lots on the installation where the staff and or patients park when the small patient parking garage is full. Which is everyday before 1000am. We are pushed and pressured by our management to issue as many tickets as possible during the day. Most of the tickets issued are against patients and staff. The WRAMC Command's solution to the parking problems at WRAMC is to have us write tickets all day long.

Their is no emphasis on Community policing or catching and arresting criminals, Just issue parking tickets against our wounded soldiers, sailors, airmen and marines and then to the staff that treat them. The Command at WRAMC utilizes us as parking enforcement agents and as Guards. When The U.S. Congress was investigating BLDG # 18. The Command of WRAMC had a police officer sit in the lobby to make the building look protected. We were never stationed in that bldg until the terrible conditions were exposed. Then we were told that we had no authority again. Just be there for show. Basically we act as night watchman. If you see a crime detain and call the police. Basically the Federal Police call the local Police to try to arrest any violator.

The Police Force is housed in an old facility, BLDG # 12 across from the Commanding Generals Homes. We have leaking water pipes on the Desk area. Numerous exposed pipes and wires. Stained ceilings, Large cockroaches that come out all hours of the day and night. Toilets that overflow into the hallway and sometimes send water almost to our locker room in the back. One of our officers recently tried to use duct tape to stop water from leaking on the desk personnel.
The building is not handicapped accessible. How ironic we have many handicapped veterans that come to the police station and if they are in wheelchairs cannot get into the station. We have to go outside to interview them. The station is in violation of the Americans with disabilities act. We have had infestations with cockroaches and sometimes mice for years.

The police station contains two executive suites on the second floor that are of high quality and utilized by visiting Generals, VIP's and or Senior personnel of the DOD, etc. Both of these suites are kept in excellent condition compared to the squalid conditions where the rank and file police work out of.
Our Station has as of late not had any heat and for the last two months the heat has not worked the majority of the time. We have terrible radios that cannot receive or transmit even a block away on occasions.

We have lost over 100 fully trained officers in the last few years. All of them sent to police academy at FLETC in Glynco, Georgia. When they get back to WRAMC they cannot do anything, cannot arrest, cannot take action in emergencies off base. Cannot perform the duties of a Federal Law enforcement officer. These officers then leave for other agencies where they are treated as police and allowed to do their jobs.

Basically the Dept. of Army hires civilians to be police and then won't let them be anything but highly trained guards with no authority over civilians. Just take MP reports about crimes for filing purposes only and issue parking tickets like a meter maid.

I ask that someone please give us the arrest powers that we need to do our job or allow us to return to the MOU of 1997 which would allow us to arrest criminals and protect the Base. I ask that the Department of Army stop using the Posse Comitatus Act to stop its civilian police from enforcing the Laws on Base or to act in an emergency off base. The Honorable Congresswoman Eleanor Holmes Norton got the Police Cordination Act of 1997 passed to allow Federal police to patrol and make arrests around and in their jurisdictions. The Command states that does not apply for we are not Federal police. The only time we are treated as police is for purposes of disciplinary action.

I ask that the whole Department of Army control of its civilian police, the lack of police powers thereof and the releasing of criminals into local communities without charges and the fact that if we do not have arrest powers then either we should stop arresting violators and just detain them at the scene of a crime not handcuff and transport them to the station and process them for hours which is an arrest and which may violate their rights by making either false arrests or unlawful seizures. Normally an arrest is made to have individuals prosecuted for committing crimes. Not just cite and or release without charges.

In summary how can we protect the injured veterans, the soldiers, sailors, airmen and marines, the staff, the visitors and family members from crimes and or assaults and protect the base, if we cannot protect ourselves as police officers. The DA and Command basically has us as private citizens in police uniforms and vehicles with guns and no powers except to issue parking tickets. This is a disgrace for the Deaprtment of Army and the Command at WRAMC to Hire so called police and treat them as less than guards. The safety and security of the Walter Reed Hospital and all the personnel who work their, the patients and families and veterans and visitors are at risk for the whole security of the base is a farce and is for show.
If you are assaulted, I cannot arrest the person who did it and even if one of my coworkers is assaulted or I in full uniform. I cannot arrest them anyway just call the D.C. police and hope they arrest them. If the police cannot protect themselves how can they protect anyone else and the Walter Reed Hospital?

Respectfully submitted
Officer Patrick Hayes

Fax Cover Sheet

Richard C. Gardner, M.D.
Board Certified Orthopedic Surgeon and Visiting Professor
5785 Riverside Drive
Cape Coral, Florida 33904
Phone and Fax: 239-549-5125

Send to:	Mr. Davis Hake	From:	Richard C. Gardner, M.D.
Attention:	Congressional Record	Date:	April 10, 2007
Office Location:	Washington, D.C.	Office Location:	Edison Office Center 2709 Swamp Cabbage Court Fort Myers, Florida 33901
Fax Number:	202-225-2544	Phone Number:	239-549-5125 (24 Hours)
Phone:	202-225-2548	Fax Number:	239-549-5125

- ❑ Urgent
- ❑ Reply ASAP
- ❑ Please comment
- ❑ For Your Review
- ❑ For Your Information

Total pages, including cover:

Re: Status of Quality Medical Care at Fort Stewart Army Hospital (Winn Army Community Hospital), Hinesville, Georgia. (Worse than Walter Reed. Unusual for mercenary/volunteer soldiers to rebel like during Vietnam War "draftees"). Response to your telephone call. Thank you for your interest in this matter.

I first complained about intolerable medical conditions at Fort Stewart (Winn Army Community Hospital) in December, 2003, but nobody would listen! They were completely understaffed and over-extended, using P.A.'s (Physician Assistants) rather than competent physicians, exceeding limitations, authority, and competence, much worse than at "Walter Reed". Most of the critical medical people were "outsourced". We all were afraid of threats over losing our jobs if we were outspoken on the topic of "inadequate medical care" for the wounded and injured soldiers from Iraq, Kosovo, and Afghanistan. There was an ongoing media blitz and congressional investigation that went nowhere. The Army violated their own rules, bypassing the recruiters and hiring me directly. My first two patients were the wounded soldiers who sparked the uprising of the troops there.

In October, 2003, despite being retired from the Air Force, I was asked to help on an emergency basis and to be active and talk to the media and congressional representatives to show that everything was stable and under control, when in fact chaos and turmoil ruled the day (cover-up by the Army). I did not ask for any monetary or financial incentives or rewards. The atmosphere at the base was totally paranoid, with concrete barriers in place all around the hospital. I responded quickly, solely for the troops and the

Country (Duty, Honor, Country), rather than for the Army, and worked hard as an Orthopedic Surgeon civilian (volunteer like I did during the war in Vietnam), at the base hospital under horrendous working conditions. I saw lots of malpractice and only quit when things were stabilized.

Call if you need anything further. I am available for direct interviews and discussions on the critical matter of lack of appropriate specialists and personnel for our troops who bravely and courageously defend our freedoms and liberties.

Sincerely,

Richard C. "Rick" Gardner, M.D.

R. C. Gardner, M.D.
Captain, U.S.A.F. Reserves/Retired
Board Certified Orthopedic Surgeon
Visiting Professor Orthopedic Surgery
Cape Coral, Florida 33904 239-549-5125 (24/7)

Enclosures

Spc. Steven Greg Jones (Army Ret.)
P.O.Box 5353
Fort Hood, TX. 76544-0353
254-535-0911

Honorable Board Members:

The conditions that my wife and I have had to endure over the past two and a half years or so should not be allowed to happen to any United States Citizens who volunteers to put their life on the line for the protection of the United States of America. I injured my back in January of 2004; while serving in Iraq at Camp Speicher. My injury was not sustained during combat; however I was in a combat zone. After my injury I was put on Tylenol 3 and muscle relaxers and still had to stand guard duty with either a SAW (M16 automatic rifle or a 50 caliber Machine gun) while under the influence of narcotics. These guard posts were not in some low threat area, they were at the main gate where you have to be on guard at all times. I have never been one for doing pills or other drugs so these medications had a strong effect on my abilities to function. After my injury I was told that soldiers were not sent back to the states for back injuries; however I recently watched A Lieutenant Colonel on C-SPAN that had injured his back in non-combat, he was sent back to the states soon after his injury, and from what I could see was doing a lot better than I am.

Since my return from Iraq in March of 2004; I have been harassed, degraded and humiliated, by both my Sergeants and Company Commander. I want to make it clear that not all of my Sergeants were bad, just the majority. These issues have not only severely affected me; they have seriously affected my wife. I was suppose to be a Firefighter; however due to my injury I have not been able to do my job. I have had NCO's accuse

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me of faking my back injury just to get out of work; I've been written up for missing work due to Doctors appointments and bounced from one position to another for having too many Doctors appointments. SFC. Rickey Williams (NCOIC Fort Hood Army Firefighters) wrote most of the early Counseling Statements and made it clear that if I did not agree with them, then my working conditions and locations could get a lot worse.

On November 4, 2005 I submitted a request for 30 days of leave (Dec. 19, 2005-Jan. 17, 2006) so that I could go home and see mine and my wife's family prior to my Back Surgery that was scheduled for Jan. 31, 2006. I had to resubmit it two more times, and change the dates the third time to 12-16-05 thru 1-14-06. On 12-14-05 (less than 48hrs before I was to sign out) I was informed that my leave was NOT going to be approved and to go see the Company Commander Cpt. Loray Thompson. After meeting with Cpt. Thompson I ended up having to go to the Battalion Commander LTC Wilcox, who had no problems approving the leave. The details of why this happened are included in a full statement that is included with this packet. After my Surgery I was placed on 45 days convalescent twice for a total of 90 days; the second "recommendation" for 45 days of convalescent leave was approved by Cpt. Thompson only because my wife went to the Battalion XO. She was forced to do this because Cpt. Thompson told my platoon sergeant to tell my wife that I needed to be at work the next working day. My wife took the leave packet to the Battalion XO who called Cpt. Thompson into his office, and only after that was the leave approved.

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At the end of the 90 days my Doctor wanted me to try and return to work on a 4 hour duty day and very light duty. I looked forward to returning to work; however within a few days I had to be taken by Ambulance to the ER because of my back. Dr. Kesling (LTC) requested 30 more days of Convalescent leave; however Cpt. Thompson totally refused the request and ordered me to work and to see the 64th CSG Primary Care Manager. He determined that I could work 6 hours a day, this was a direct contradiction of what two Medical Specialists (Dr. William Marsh Pain Mgmt and Dr. Kimberly Kesling LTC US Army) put in writing. The only way this was possible for me was with heavy Medication (Percocet, Soma, Zoloft, Neurotin, valium, Ultracet, and over time had to be put on many others since none of them gave me much relief) needless to say I was not able to drive my self to and from work, so this burden fell to my wife. The combination of appointments, duty hours and the fact that my wife must help me do most of the normal activities we take for granted such as; bathing, dressing, preparing a simple meal etc... caused her to drop out of College for several months and a lot of Stress. She is graduating this May; however she could've graduated in December 2006. These issues were brought to Cpt. Thompson's attention by me and his response was "that's not my problem"!

On two separate occasions my wife attempted to see the Base Commander since all other complaint channels had failed, and she thought they had an open door policy; however she was turned away both times. Any complaints I tried to make using my chain of command only brought more problems to my situation; at the time I really didn't care because I wanted to get Cpt. Thompson literally off my back. I was pushed to the

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limit but thanks to my wife's support and anti-depressant medication, I was somewhat able to control myself. My brother-in-law, a Retired Sergeant Major gave me a lot of advice and recommendations to help us get through this time.

Doctors told me that whatever orders they gave were only a "recommendation" and my Commander had the final say. My wife has calculated more or less how many extra hours I had to work, and it comes up to approx. 400 hours that according to my Doctors I should not have worked. It makes me wonder if that could have made an impact on my current health status, which is not good. Also I have a doctor's appointment coming up that should tell me if my L-5/S-1 disc has also been affected because of this situation, if so I can only wander if it is due to Cpt. Thompson's insistence to not follow my Doctors "recommendations".

I can tell you that my story is not alone, I have personally spoke with many other injured soldiers while waiting at Doctors appointments that have told me about the same problems they have with their Units. These were soldiers from every Division stationed here at Fort Hood, with all types of injuries both combat and non-combat related. It's bad enough to be injured but to be treated like dirt by the people who are suppose to be your support is enough to drive even the most sane person to become suicidal or even homicidal. How much sense does it make that soldiers can fail drug tests multiple times, and be treated better than an injured one?

If I can stop one soldier from going through the same mental abuse and physical pain I went through, it would be the worth everything I have been through, and the best reward I can ever get out of all of this. My pain may never go away; even when I wanted

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to continue my career in the Army, my doctor advised me that it wouldn't be possible. Maybe if I would have time to heal from my surgery I would be where I belong, serving my country. Thank you.

Cordially

SPC Steven G. Jones (US Army Ret.)

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Recommendations

Soldier's Working Environment at Fort Hood

- Officers should be held to higher standards for their behavior, instead of letting them get off with a slap on the wrist because of their rank. A good leader should show respect, compassion, and care for their soldiers, and they should lead by example. Officers are supposed to have better training on work ethics, and handling delicate working environment situations. Officers should be reviewed or evaluated at least annually, the same as soldiers are currently required to be.
- Change Army Regulation that allows Unit Commanders to decide on health issues, and give trained professionals (Doctors) the power to decide whether the soldier should work at all or how many hours. Injured soldiers should get the time a doctor considers appropriate for rehabilitation. Doctor's orders should supersede Unit Commander's orders regarding soldier's health care.
- Specialist doctors such as Dr. Kimberly Kesling (Orthopedic Surgeon) and Dr. William Marsh III (Pain Management) shouldn't be overwritten by a Primary Care Manager such as Dr. David Bauder at Thomas Moore Clinic.
- Have the Inspector General Office, Chain of Command, and the Equal Opportunity Office follow up on complaints. Soldiers should not be afraid of reporting incidents that are affecting their work environment. Inspector General offices should not be located near their brigades; this would minimize the risk of building friendships between Unit Commands and Inspector General Offices.

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This will decrease the likelihood of having a conflict of interest in situations like mine.

Health Management Issues at Darnall Community Hospital

- Rank shouldn't have preferential treatment. Rank should be respected but not abused. When it comes to health issues, injuries or illnesses should take precedence over rank.
- To get an authentic assessment of patient/soldier care at any hospital or unit, an inspection should be done without any notice. The inspector should speak directly to unaware patients/soldiers at waiting areas in the hospital or where soldiers usually congregate. This can be done by using a person posing as another patient/soldier. Any patient/soldier would be more than willing to share their experiences with the inspector just like they have done with me.
- Provide soldiers with a broader mental health program that includes more Psychiatrists and Psychologists at Darnall Army Community Hospital. They are overwhelmed at the moment; soldiers shouldn't have to wait three weeks or go on a waiting list to get an appointment.
- Make it a "culture" for hospital staff such as: Nurses, receptionists, and any other employees to treat patients with respect, patience and care. An injured soldier needs support from everyone he/she encounters at a hospital, not indifference and disrespect. (The majority of the staff at Darnall act like they are doing the patient a favor and soldiers mean nothing to them.)

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- The Emergency Room waiting time for a person with a back injury is about 4.5 hours. If there is a document from a doctor that states that the patient can not sit or stand for more than 20 minutes they should have some kind of priority.
- The Pharmacy at Darnall Army Community Hospital handles around 500 hundred patients a day. The system that is currently in place, which is "take a number and wait", is not feasible for patients that have physical disabilities, patients that have to work, and patients with kids. The average wait during the day is about two hours; I have seen the pharmacy at BAMC work more efficiently. There should be other pharmacies available for drop off and pick up other than the one at DACH. Patients should be able pick up their prescriptions at any pharmacy on Base.

Tricare Prime Management Issues

- DEERS and Tricare should become one department to eliminate lack of communication and mistakes between departments. Tricare should be as easy to understand as the federal healthcare program provided for civilian employees. Benefits should be in a "clear and precise" format so that everyone could understand; they shouldn't change policy carriers (Humana, Blue Cross etc...) so often.
- To minimize the occurrence of lost and wrong information provided to members of Tricare, contractors such as Humana should have standard guidelines and policies as the previous carrier. Every time contractors are changed the guidelines and policies change without notifying members of the changes, therefore affecting

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their coverage, and costing them money that will never be returned to them because of loop holes in the system.

- Tricare needs a training that is a pass or fail, and not just take this 15 minute online course. An employee with a failed training should mean they need more training, and should not be advising members on their benefits. Three different calls can give a member three completely different answers.
- Don't waste money by sending every patient on Tricare Prime to get a referral from their Primary Care Manager for an existing injury. Tricare Prime is not only paying for a doctor's visit for a referral; it is also overwhelming the Primary Care Manager by sending every patient to get a referral for an existing condition that needs constant care. In my experience, some conditions that could be included in this category are: Back pain management, follow up/check ups after a surgery, and psychiatric care. This could free up appointment time for the Primary care Doctors to take of the Patients that need to be seen that day.

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The main people I hold directly responsible for harassing and degrading me are:

CPT Loray Thompson 664th Ordnance Company

SFC Rickey Williams NCOIC Fort Hood Firefighters

SSGT Eric Mattson (Fort Hood Fire Department)

SSGT Washington (Fort Hood Fire Department)

The Following did nothing to fix the problems are:

MSG Holderman 13 Cos Com IG

LTC Erickson 2nd Chemical BN

CW Lieuders III Corp IG

The People that I would like to express my appreciation to for their help and support are:

1SG Gene Canada 664th Ordnance Co

SSGT Myers 664th Ordnance Co Operations NCO

SSGT Iris McCollum 664th ORD Co. Headquarters platoon Squad Leader.

SGM Jose E. Betancourt (US Army Ret.)

LTC David Wilcox 64th CSG

SGM Richardson 64th CSG

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Current Situation of Cpl Steven K. Schulz, USMC (ret) 0502 as of 4/1/07

- Steven was retired from the USMC on 12/28/06.
- In January 2007, Steven had surgery for the implantation of a Baclofen Pump. TRICARE approved this procedure in a network facility (this procedure was recommended by physicians at the Houston VA) and TRICARE has paid for the services. Steven had to pay a $500 deductible payment to have the surgery.
- Steven has since had follow-ups with a physician monitoring the Baclofen pump who is outside of the TRICARE network and TRICARE has paid the physician. Steven has had to pay $200 out of pocket for these services.
- TRICARE is now denying a request for rehabilitation in the same "out of network" facility (The Institute of Rehabilitation and Research (TIRR) www.tirr.org) that TRICARE had approved and allowed Steven to receive multiple rehabilitation services while Steven was active in the USMC. TIRR contact is Jesse Burks 713-799-5022.
- Steven should have had a TRICARE "case manager". Steven was never notified or contacted by anyone from TRICARE that identified themselves as a "case manager" until 3/29/07. This was only after our persistence in requesting a case manager be assigned.
- A Case Manager, we are finding out now, would have been valuable in regard to advice concerning the differences between TRICARE Prime and TRICARE Standard coverage. Steven chose TRICARE Prime coverage at the time of his retirement based on advice from the USMC, VA Social Workers and information gathered from the TRICARE website.
- We are now being told by the new TRICARE Case Manager, Michelle Johnson (1-800-444-5445, ext.2371) that because of Steven's needs for "out of network" services that the TRICARE Standard coverage may be the best choice even though this will cost Steven up to 25% or $3,000 per year out of pocket per year.
- TRICARE needs to approve Steven's rehabilitation at The Institute of Rehabilitation and Research (TIRR), now!
- Steven sacrificed more than is imaginable for this government, and now when he needs government more than ever, his problems are being outsourced onto the back of the family and he is not receiving the care he needs to maximize his recovery. ***Why do Steven and other severely injured service members have to pay any out of pocket for medical treatment?***

Sincerely,

The Family of Steven Schulz

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3/24/07

History: On April 19, 2005, while serving his second tour in Iraq, my son, Lcpl Steven K. Schulz was severely injured in an Improvised Explosive Device (IED) attack and sustained a Traumatic Brain Injury (TBI). Shrapnel entered Steven's brain through his right eye and forehead. Steven was initially treated in Iraq and at the National Naval Medical Center in Bethesda, MD. Steven was then transferred to the James V. Haley VA Hospital, Tampa, FL to start rehabilitation, June 8-August 1 2005. We were strongly encouraged to use one of the four DOD/VA designated "traumatic brain injury" centers. *We were not given options to utilize specialty hospitals in our home area, nor were we ever advised that this was an alternative by using Steven's military TRICARE insurance.* The strain, both emotional and financial, that treatment at a facility nearly 1000 miles away places on a family of a severely injured service member is enormous. He was then transferred to Michael E. Debakey VA hospital (Houston, TX), to be closer to our home in Friendswood, August 1- August 8, 2005. Because of a threatening brain aneurysm, Steven returned to the National Naval Hospital for eight weeks, where most of his treatment (aneurysm related) was outpatient. Steven was placed on convalescent leave and returned home to his family on October 20, 2005 as an active duty Marine. Eventually, with the guidance of a social worker affiliated with Michael E. Debakey VA, we stumbled onto the option of having Steven's treatment done locally using TRICARE. After much back and forth with TRICARE, Steven was admitted into The Institute of Rehabilitation and Research (TIRR) for outpatient therapy in mid-November 2005. Since that time, Steven has had combined medical care at Michael E. Debakey VA as well as with a private sector hospital utilizing TRICARE.

Medical Condition: Steven has been rated at 100% disabled by the Medical Boards and was rated 100% disabled by the VA with additional compensation for aid and attendance. Competitive employment is not an option at this time or for the foreseeable future. His most recent surgery was to implant a Baclofen pump, which will hopefully allow Steven to walk independently. Another round of rehab is being scheduled. Cognitively Steven continues to have deficits that preclude his being left alone.

Family Role in Care: Steven's main caregiver from August, 2005 to present continues to be his mother, Debbie Schulz. Additional care comes from the rest of his family. Steven required and continues to require 24-hour care. This care consists of all the basic needs a person requires in addition to the unique needs of TBI patient. A partial list includes: preparation of all meals, supervision and assistance with toileting, showering, dressing, mobility, medication, transportation and laundry. Steven is incapable of self-care at this time.

Family Financial Impact: We have been told numerous times through this ordeal that attendant care was not available through the USMC, Tri-Care, DOD or the VA. I, Steven's mother, had to resign my job as a high school teacher in order to care for Steven. Steven has had to contribute to his family out of his pay to satisfy some of the financial burden. In the last six months, we have been made aware of a Memoranda of Agreement (MOA) that addresses this issue for TBI patients; it was signed in March and April of 2004. This benefit was never afforded to us because nobody we asked knew about it. Recently, Steven was awarded his VA benefits with the added stigma of being found incompetent. According to the VA fiduciary representative, this money must be spent according to their prescribed budget, with no regards to our family's financial hardship after losing one salary. To date, we estimate the total financial hardship due to the loss of income to be $65,000; not to mention the loss of my own retirement

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growth. This is not a complaint about money, but about how DoD/VA "systems" fail to provide care and services that would have alleviate many stresses during a very stressful situation. And now the system continues to neglect families who are being true caregivers 24/7. On a personal level, we feel as if our son sacrificed more than is imaginable for this government, and now when he needs government more than ever, his problems are being outsourced onto the back of the family. What we want is to care for Steven, we chose to care for Steven, but it does not seem right that we are punished financially in order to do so. The ironies are: I can pay a caregiver to attend to Steven, but I cannot pay myself. I can put him in a assisted living home that will likely use all but $90 of his pension, but that money cannot be utilized to offset costs in the loving, caring, therapeutic environment of his home, all because he has a TBI that has made him incompetent to handle his funds.

Conclusion: Steven was an active duty US Marine until December 28, 2006 and has been cared for 24 hours a day by his family for the last year and a half. NO COMPENSATION FOR CAREGIVING WAS OFFERED BY THE DoD. When we contacted our Senator, we received a form letter signed by a staffer, with no relief or assistance offered. Currently, Steven is retired with a VA pension, and because he needs assistance with financial matters, NO COMPENSATION CAN BE GIVEN. I've been told that the TGSLI award that Steven was granted should be utilized. That money was given with cautions of saving for the long term, with no mention of using it to assist families in providing on going care for their injured Marine.

Key points to remember: 1) We provided high quality 24/7 care with no in-home assistance for many months. When requesting help none was given. When help was given it was not suitable for Steven's needs. Help should have been given immediately. The DoD/VA must develop appropriate and individualized programs for this special population. Geriatric programs are not appropriate nor are they suitable for a twenty-two year old service member.
2) Now, transitioning to the VA system, because of Steven's type of injury his financial affairs are prescribed by people who give no regard to the family's financial sacrifices or needs. Families should not be punished financially because they want to provide the best for their service member.
3) The biggest sin the DoD committed was not making available the very best medical resources after the acute phase of injury. Houston has a world class rehab hospital that has worked with people with TBI for decades. When we inquired about facilities closer to home, no one told us how that could be accomplished. Why wasn't that given as an option for Steven's care?

Possible Solutions: 1) We strongly assert that service members ought to remain on active duty until they have exhausted all medical care available to them, as this is what the MilPersMan or SecNav Instruction already calls for) However, we recognize remaining active duty makes the service member ineligible for many VA benefits and entitlements. We recognize that efforts have been made to increase the number of programs available to active service members however more needs to be done. We propose that benefits such as the VA's Aide and Attendant Allowance (and all VA Title 38, Chapter 31 Vocational Rehabilitation and Employment VR&E benefits) be available to active service members (possibly with a memorandum rating of 20% or more). The current DoD/VA MOU in place should be utilized to cover healthcare expenditures and should be expanded to allow for VA to charge-back DoD for services and benefits provided to active service members. Specifically, family members that function as primary care-givers to active service members should be given the same monthly stipend as veterans to assist with this type of care.

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2) We feel strongly that each severely injured service member should be assigned a case manager at the onset of the injury and that case manager will follow that individual throughout his/her recovery. This case manager will be an advocate for the service member and will assist with finding the best quality care, while navigating multiple agencies/systems. Ideally this case manager should fall under the auspices of DoD and carry enough authority to ensure that all ancillary agencies assisting the severely injured service member act in accordance with current policies and regulations. Secondly, we would request that a thorough training package be developed for case managers and other injured support personnel. We were not provided opportunities early on to utilize programs that would have assisted with care at home, especially a progression from nursing care to companion care at home would have alleviated much stress on the family.

3) TSGLI. There is much confusion over the stated purpose of TSGLI. The program coverage has been described as a payment to cover additional expenses associated with injury from the point of injury until separation occurs and VA compensation begins. However, Steven was encouraged to utilize financial counselors who encouraged investing the claim money in order to maximize potential earnings and longevity. We request clarification of the intent of TSGLI and would like acknowledgement that the TSGLI money is not set-up for family member expenses but for the injured service member alone. Additionally, clarification that the TSGLI money is not to fund healthcare/homecare for service members, rather, other funding should be available to fund the expenses associated with care.

Lessons Learned: It has been 23 months since we received the fateful phone call telling us our son, Cpl Steven K. Schulz, had sustained a "very serious injury" due to an Improvised Explosive Device. That was the start of a very fast learning curve that has taught us about the best and the worst of military and Veteran's Administration care and services. The best: doctors, nurses, social workers, Marines, and ordinary people doing what they can to save lives, make lives more comfortable, and meeting the needs of the injured and their families. The worst: bureaucracy that is unyielding and thus not meeting the needs of special populations as they come from the war front.

Respectfully submitted,

Debbie Schulz
Mother of Cpl. Steven K. Schulz, USMC (ret.)

Statement of Officer Patrick Hayes,
Department of Army civilian Police Officer at Walter Reed

I would like to submit the following as my testimony concerning the terrible conditions at Walter Reed Hospital and the fact that the Police force is forbidden by the Department of the Army and The Command at Walter Reed from arresting civilian criminal violators and that we are routinely instructed to release civilian violators on instant bar letters and no charges if the D.C. police do not assume jurisdiction of them. We are told that we have no arrest power whatsoever and basically we are treated as less than guards. Prior to September 11th, 2001 we had a memorandum of understanding signed in 1997 with the D.C. Police that allowed us to arrest and process civilian criminal violators utilizing D.C. paperwork and facilities. Shortly after 9-11 we were instructed to not arrest civilians anymore and to call the D.C. police.

The Department of the Army and the Command of Walter Reed state that we have never had arrest powers and that we can only detain civilians and military offenders and release them to either civil or military authorities. We cannot even stop a crime in progress outside of our gates and are forbidden to intervene even if we see the crime being committed. The Command and the Department of Army have included us by their policy not law under the restrictions of the Posse Commitatus Act of 1878 which forbids under Title #10 USC military troops from enforcing laws against civilians. The Command and the Army states that we are not even Federal Police, that we are civilian employees with limited police power confined to the Installation, Even though we are all hired under the OPM GS-0083 Federal Police series and trained and equipped and wear uniforms and weapons and drive marked police vehicles.

Whoever heard of Police that cannot arrest? If I were to be assaulted in full uniform by a civilian violator, I have to call the local police and hope that they arrest the individual. if not just take them to the gate and let them into the local community without charges. If I cannot arrest someone that would strike a uniformed police officer, how can I protect anyone?

The Department of Army will not even allow us to be commissioned as Special Police Officers to make arrests, if it is in fact true that we do not have statutory police powers of arrest. Yet if we do not have arrest powers then why do we and I on many occasions have responded to calls for police service on the installation and have taken civilians and military personnel against their will, handcuffed, transported in a marked police vehicle to our station, BLDG # 12, Where we advice them of their rights, Keep them for hours, Take statements, process them on Military police paperwork and then release them which is according to the U.S. Supreme Court and the United States Constitution an arrest. The Army and our Command call it a brief detention. I feel as though I am violating the Constitution by willfully arresting people that the Command and The Army have no intention of prosecuting.

The Command at WRAMC would rather we just issue numerous parking tickets, D.C. notices of infraction against the soldiers and staff to include the wounded warriors at BLDG # 14, BLDG # 20 the Mologne Hotel, BLDG # 6 the Dept. of psychiatry, The patient parking garage and all the open parking lots on the installation where the staff and

or patients park when the small patient parking garage is full. Which is everyday before 1000am. We are pushed and pressured by our management to issue as many tickets as possible during the day. Most of the tickets issued are against patients and staff. The WRAMC Command's solution to the parking problems at WRAMC is to have us write tickets all day long.

Their is no emphasis on Community policing or catching and arresting criminals, Just issue parking tickets against our wounded soldiers, sailors, airmen and marines and then to the staff that treat them. The Command at WRAMC utilizes us as parking enforcement agents and as Guards. When the U.S. Congress was investigating BLDG # 18. The Command of WRAMC had a police officer sit in the lobby to make the building look protected. We were never stationed in that bldg until the terrible conditions were exposed. Then we were told that we had no authority again. Just be there for show. Basically we act as night watchman. If you see a crime detain and call the police. Basically the Federal Police call the local Police to try to arrest any violator.

The Police Force is housed in an old facility, BLDG # 12 across from the Commanding Generals Homes. We have leaking water pipes on the Desk area. Numerous exposed pipes and wires. Stained ceilings, large cockroaches that come out all hours of the day and night. Toilets that overflow into the hallway and sometimes send water almost to our locker room in the back. One of our officers recently tried to use duct tape to stop water from leaking on the desk personnel.
The building is not handicapped accessible. How ironic we have many handicapped veterans that come to the police station and if they are in wheelchairs cannot get into the station. We have to go outside to interview them. The station is in violation of the Americans with disabilities act. We have had infestations with cockroaches and sometimes mice for years.

The police station contains two executive suites on the second floor that are of high quality and utilized by visiting Generals, VIP's and or Senior personnel of the DOD, etc. Both of these suites are kept in excellent condition compared to the squalid conditions where the rank and file police work out of.
Our Station has as of late not had any heat and for the last two months the heat has not worked the majority of the time. We have terrible radios that cannot receive or transmit even a block away on occasions.

We have lost over 100 fully trained officers in the last few years. All of them sent to police academy at FLETC in Glynco, Georgia. When they get back to WRAMC they cannot do anything, cannot arrest, and cannot take action in emergencies off base. Cannot perform the duties of a Federal Law enforcement officer. These officers then leave for other agencies where they are treated as police and allowed to do their jobs.
Basically the Dept. of Army hires civilians to be police and then won't let them be anything but highly trained guards with no authority over civilians. Just take MP reports about crimes for filing purposes only and issue parking tickets like a meter maid.

I ask that someone please give us the arrest powers that we need to do our job or allow us to return to the MOU of 1997 which would allow us to arrest criminals and protect the Base. I ask that the Department of Army stop using the Posse Comitatus Act

to stop its civilian police from enforcing the Laws on Base or to act in an emergency off base. The Honorable Congresswoman Eleanor Holmes Norton got the Police Cordination Act of 1997 passed to allow Federal police to patrol and make arrests around and in their jurisdictions. The Command states that does not apply for we are not Federal police. The only time we are treated as police is for purposes of disciplinary action.

I ask that the whole Department of Army control of its civilian police, the lack of police powers thereof and the releasing of criminals into local communities without charges and the fact that if we do not have arrest powers then either we should stop arresting violators and just detain them at the scene of a crime not handcuff and transport them to the station and process them for hours which is an arrest and which may violate their rights by making either false arrests or unlawful seizures. Normally an arrest is made to have individuals prosecuted for committing crimes, not just cite and or release without charges.

In summary how can we protect the injured veterans, the soldiers, sailors, airmen and marines, the staff, the visitors and family members from crimes and or assaults and protect the base, if we cannot protect ourselves as police officers. The DA and Command basically has us as private citizens in police uniforms and vehicles with guns and no powers except to issue parking tickets. This is a disgrace for the Department of Army and the Command at WRAMC to hire so called police and treat them as less than guards. The safety and security of the Walter Reed Hospital and all the personnel who work their, the patients and families and veterans and visitors are at risk for the whole security of the base is a farce and is for show.
If you are assaulted, I cannot arrest the person who did it and even if one of my coworkers is assaulted or I in full uniform. I cannot arrest them anyway just call the D.C. police and hope they arrest them. If the police cannot protect themselves how can they protect anyone else and the Walter Reed Hospital?

Respectfully Submitted
Officer Patrick Hayes

Initial e-mail contact:

Name: Ofc. Patrick K. Hayes

Your Message: Dear Chairman the Honorable Mr. Waxman,

I am writing this email to you and your Committee in regards to the Walter Reed Army Medical Center. I am a Department of Army civilian Police Officer at Walter Reed and have been since June of 1987. The Civilian police force at Walter Reed since November 0f 2001 has been forbidden to arrest and process, utilizing D.C. police paperwork any civilians who commit crimes against soldiers or against other civilians on the installation. The Command of WRAMC and the Dept. of Army state that even though we are civilians working for the Army we are forbidden to arrest because of the PCA of 1879, which normally only covers Military personnel under title 10 of the U.S. Code. We currently work out of Bldg # 12 at WRAMC. The Building we are in has numerous problems including exposed wires and pipes. We have large cockroaches and mice. The basement where we work out of is just as bad, if not worse than bldg # 18. Our station is not even handicapped accessible and our heat was off for over 2 weeks and our sub station in MD is just as bad. The Dept Of Army has issued a new regulation effective in Sept. 2006 (AR 190-56) which states that we have no arrest powers and that we can only issue tickets. The former Commander of WRAMC Lt. General Kiley was made aware of the no arrest policy at WRAMC about 6 months after he took Command of the facility and to date the situation has only gotten worse. We are only allowed to write parking tickets and moving violation tickets against the staff and patients. The agency does not have enough parking for the patients and even encourages us to write numerous tickets against the staff and patients for minor parking infractions. Our police force has lost over 100 officers in the last 6 yrs because of the no arrest policy, the working conditions and the Commands continued micromanagement of the Base Police force. We have only about 40 police officers, and someday there are only 2 uniformed police on patrol to protect the patients and staff. The Dept. of Army now wants to make this no arrest policy uniform throughout the Army. There are many installations statewide now that have civilian police on them as opposed to MP's. The Army at WRAMC treats its police as less than guards and continually reminds them they are not police and cannot arrest anyone. that we detain civilians and military personnel for crimes and turn them over to others. Basically the police have to call the police to get anyone hopefully arrested for criminal acts. If not we take civilians to the gate and release them back into the local community with a bar letter. Our current Chief of police Ms. Joanne Beard has tried to fix the problems to no avail. The climate at WRAMC is that we post a police officer in the crosswalk of the Command Bldg # 1 during rush hr. to help them cross the street, even though if a police officer was needed to be anywhere to perform crossing guard duty, it should be at BLDG # 20 the Mologne Hotel where our amputees and seriously injured troops are housed. We now issue tickets every day except weekends for parking violations.there is no emphasis on even trying to find criminals or to arrest anyone on the campus for any violation. We have been told that we are supposed to have a 400 percent turnover rate and that we are not police just civilian employees with limited police power. Yet we do handcuff and bring individuals to our dilapidated station which is an arrest

according to law. We hold them for hrs. and then let them go if they are civilians and if military turn them over to their Company Commander for disposition. Our Agency spends about $5000.00 per officer to send them to the Federal Police academy in Georgia. Then when they get back to the agency they are forbidden to perform law enforcement work except issue tickets. This is disgraceful and a waste of the taxpayers money. Our station is not even accessible in accordance with the ADA laws. I ask you how can the base police protect our injured troops and the staff and many visitors of Walter Reed if they are not even allowed to arrest a civilian who may assault them. I ask that your Committee while investigating Walter Reed, Please take the time to include the state of the police force at the installation and the state of all the DA police who are employed across the nation to protect our Military installations. I may be contacted at telephone number 240-601-2109 and my work number is 202-782-7511. Any help you can give us would be greatly appreciated. With best regards always.
Ofc. Patrick K. Hayes